The Montana Administrative Register (MAR or Register), a twice-monthly publication, has three sections. The Proposal Notice Section contains state agencies' proposed new, amended, or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted. The Rule Adoption Section contains final rule notices which show any changes made since the proposal stage. All rule actions are effective the day after print publication of the adoption notice unless otherwise specified in the final notice. The Interpretation Section contains the Attorney General's opinions and state declaratory rulings. Special notices and tables are found at the end of each Register.

Inquiries regarding the rulemaking process, including material found in the Montana Administrative Register and the Administrative Rules of Montana, may be made by calling the Secretary of State's Office, Administrative Rules Services, at (406) 444-2055.

Page Number

TABLE OF CONTENTS

PROPOSAL NOTICE SECTION

SPECIAL NOTICE AND TABLE SECTION

BEFORE THE DEPARTMENT OF COMMERCE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 8.119.101 pertaining to the Tourism Advisory Council	)))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On August 5, 2009, at 1:30 p.m., the Department of Commerce will hold a public hearing in Room 228 of the Park Avenue Building at 301 South Park Avenue, at Helena, Montana, to consider the proposed amendment of the above-stated rule.

2. The Department of Commerce will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact Department of Commerce no later than 5:00 p.m. on July 24, 2009, to advise us of the nature of the accommodation that you need. Please contact Barbara Sanem, Department of Commerce, Montana Promotion Division, 301 South Park Avenue, P.O. Box 200533, Helena, Montana 59620-0533; telephone (406) 841-2769; fax (406) 841-2871; TDD (406) 841-2702; or e-mail bsanem@mt.gov.

3. The rule as proposed to be amended provides as follows, new matter underlined, deleted matter interlined:

8.119.101 TOURISM ADVISORY COUNCIL (1) remains the same.

(2) The Tourism Advisory Council incorporates by reference the guide entitled "Regulations and Procedures for Regional/CVB Tourism Organizations, February 2009, as amended June 2009," setting forth the regulations and procedures pertaining to the distribution of lodging facility use tax revenue. The guide is available for public inspection during normal business hours at the Montana Promotion Division, Department of Commerce, 301 South Park Avenue, Helena, Montana 59620. Copies of the guide are available on request.

(3) Distribution of funds to regional nonprofit tourism corporations and to nonprofit convention and visitors" bureaus is contingent upon compliance with the "Regulations and Procedures for Regional/CVB Tourism Organizations, February 2009, as amended June 2009."

AUTH: 2-15-1816, MCA
IMP: 2-15-1816, MCA

REASON: It is reasonably necessary to amend this rule because the "Regulations and Procedures for the Regional/CVB Tourism Organizations, February 2009" were amended by the Tourism Advisory Council in June 2009 to allow Regional/CVB Tourism Organizations to host their web site on a nondepartment server.

4. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Barbara Sanem, Department of Commerce, Montana Promotion Division, 301 South Park Avenue, P.O. Box 200533, Helena, Montana, 59620-0533; telephone (406) 841-2769; fax (406) 841-2871; or e-mail bsanem@mt.gov, and must be received no later than 5:00 p.m., August 13, 2009.

5. Kelly A. Casillas, Legal Counsel, Department of Commerce, has been designated to preside over and conduct this hearing.

6. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 4 above or may be made by completing a request form at any rules hearing held by the department.

7. An electronic copy of this Proposal Notice is available through the Secretary of State"s web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

8. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

/s/ KELLY A. CASILLAS
KELLY A. CASILLAS
Rule Reviewer

/s/ ANTHONY J. PREITE
ANTHONY J. PREITE
Director
Department of Commerce

Certified to the Secretary of State July 6, 2009.

BEFORE THE BOARD OF DENTISTRY
DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.138.508 dental anesthetic certification, 24.138.509 dental permits, and 24.138.2106 exemptions - continuing education	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On August 11, 2009, at 1:30 p.m., a public hearing will be held in room 439, 301 South Park Avenue, Helena, Montana to consider the proposed amendment of the above-stated rules.

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Dentistry (board) no later than 5:00 p.m., on August 6, 2009, to advise us of the nature of the accommodation that you need. Please contact Traci Collett, Board of Dentistry, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2390; Montana Relay 1 (800) 253-4091; TDD (406) 444-2978; facsimile (406) 841-2305; e-mail dlibsdden@mt.gov.

3. The rules proposed to be amended provide as follows, stricken matter interlined, new matter underlined:

24.138.508 DENTAL HYGIENE LOCAL ANESTHETIC AGENT CERTIFICATION (1) through (3)(d) remain the same.

~~(e) verification of successful completion of a local anesthetic agent course given by a Commission on Dental Accreditation (CODA) accredited dental or CODA accredited dental hygiene school. The only verification that will be accepted is one of the following:~~

~~(i) a letter from the school with the school seal affixed (photocopies will not be accepted);~~

~~(ii) a notarized copy of the certification of local anesthetic agent course completion; or~~

~~(iii) a notarized copy of the dental or dental hygiene transcript with the local anesthetic agent course recorded.~~

(f) remains the same but is renumbered (e).

~~(g)~~ (f) written verification from a supervising dentist that the applicant has practiced administering local anesthetic agents within the last five years.

(4) through (c) remain the same.

~~(d) verify successful completion of a local anesthetic agent course given by a CODA accredited dental or CODA accredited dental hygiene school. The only verification that will be accepted is one of the following:~~

~~(i) a letter from the school with the school seal affixed (photocopies will not be accepted);~~

~~(ii) a notarized copy of the certification of local anesthetic agent course completion; or~~

~~(iii) a notarized copy of the dental or dental hygiene transcript with the local anesthetic agent course recorded.~~

(e) remains the same but is renumbered (d).

~~(f)~~ (e) written verification from a supervising dentist that the applicant has practiced administering local anesthetic agents within the last five years.

(5) The application remains valid for six months from the time it is received in the office. If not completed within six months, the application will be considered incomplete and a new application and fee must be submitted.

AUTH: 37-1-131, 37-4-205, 37-4-402, MCA
IMP: 37-1-131, 37-4-401, 37-4-402, MCA

REASON: The board determined it is reasonably necessary to strike the specific requirement of successful completion of a local anesthetic course by a Commission on Dental Accreditation (CODA) school to qualify for dental hygienist local anesthetic certification. This course is a prerequisite for applicants to qualify to take the Western Regional Examining Board (WREB) exam, which is already required in this rule. The board is also amending this rule to address applicant questions by specifying that a supervising dentist must provide the written verification of an applicant's experience. The board is adding (5) to clarify that application materials are valid and will be kept for six months after receipt in the board office. The board concluded that tracking applications indefinitely is not practical and that after six months some materials become stale and require resubmission.

24.138.509 DENTAL HYGIENE LIMITED ACCESS PERMIT (1) through (5)(b) remain the same.

(c) Harlem Elementary School; ~~and~~

(d) Harlem Junior/Senior High School~~.~~ ; and

(e) Paris Gibson Education Center.

AUTH: 37-1-131, 37-4-205, 37-4-405, MCA
IMP: 37-4-405, 37-4-406, MCA

REASON: Following a licensee's request to provide dental hygiene services under a limited access permit (LAP) in an alternative setting, the board is amending this rule to designate the Paris Gibson Education Center as an additional public health facility or program at which services can be provided under a LAP. Implementation cites are being amended to accurately reflect all statutes implemented through this rule.

24.138.2106 EXEMPTIONS AND EXCEPTIONS (1) through (3) remain the same.

(4) Volunteer licensees shall be exempt from the continuing education requirements.

AUTH: 37-1-319, 37-4-205, 37-29-201, MCA
IMP: 37-1-306, 37-4-205, 37-29-306, MCA

REASON: The board determined it is reasonably necessary to add (4) to this rule and clarify that volunteer licensees are exempt from continuing education (CE) requirements. The board concluded that it is not necessary for volunteer licensees to obtain CE for the limited scope of their license and is amending the rule accordingly.

4. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Board of Dentistry, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or by e-mail to dlibsdden@mt.gov, and must be received no later than 5:00 p.m., August 19, 2009.

5. An electronic copy of this Notice of Public Hearing is available through the department and the board's site on the World Wide Web at www.dentistry.mt.gov. The department strives to make the electronic copy of this Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

6. The board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies the person wishes to receive notices regarding all board administrative rulemaking proceedings or other administrative proceedings. The request must indicate whether e-mail or standard mail is preferred. Such written request may be sent or delivered to the Board of Dentistry, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, faxed to the office at (406) 841-2305, e-mailed to dlibsdden@mt.gov, or made by completing a request form at any rules hearing held by the agency.

7. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

8. Darcee Moe, attorney, has been designated to preside over and conduct this hearing.

BOARD OF DENTISTRY
PAUL SIMS, DDS, PRESIDENT

/s/ DARCEE L. MOE
Darcee L. Moe
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State July 6, 2009

BEFORE THE BOARD OF NURSING HOME ADMINISTRATORS
DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.162.420 fee schedule, 24.162.501 documentation for licensure, 24.162.506 temporary permit, 24.162.510 reciprocity licenses, and 24.162.2105 continuing education	)))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On August 11, 2009, at 10:00 a.m., a public hearing will be held in room 439, 301 South Park Avenue, Helena, Montana to consider the proposed amendment of the above-stated rules.

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Nursing Home Administrators (board) no later than 5:00 p.m., on August 6, 2009, to advise us of the nature of the accommodation that you need. Please contact Linda Grief, Board of Nursing Home Administrators, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2395; Montana Relay 1 (800) 253-4091; TDD (406) 444-2978; facsimile (406) 841-2305; e-mail dlibsdnha@mt.gov.

3. The rules proposed to be amended provide as follows, stricken matter interlined, new matter underlined:

24.162.420 FEE SCHEDULE (1) remains the same.

(a) application fee	~~$160~~ 225
(b) jurisprudence reexamination	~~50~~ 75
(c) inactive renewal fee	~~75~~ 100
(d) active renewal fee	~~185~~ 235
(e) temporary permit	~~160~~ 200
(f) reciprocity	~~260~~ 275

(2) through (4) remain the same.

AUTH: 37-1-131, 37-1-134, 37-9-304, MCA
IMP: 37-1-131, 37-1-134, 37-1-141, 37-9-304, MCA

REASON: The board has determined that there is reasonable necessity to make the proposed fee changes to comply with the provisions of 37-1-134, MCA, and keep the board's fees commensurate with associated costs. The department, in providing administrative services to the board, has determined that unless the licensure fees

are increased as proposed, the board will have a shortage of operating funds by 2010. The board and department engaged in lengthy debate and research in reaching this conclusion, including a thorough review of the board's current and past expenses, revenue, fees, and licensing trends. In addition, the board has researched licensing fees for nursing home administrators in surrounding states and reviewed licensing fees in Montana for other professions who have a similar number of licensees. The board estimates that approximately 261 individuals will be affected by the proposed fee changes. The estimated annual increase in revenue is approximately $6360. The board last raised its fees in 2005.

24.162.501 APPLICATION AND DOCUMENTATION FOR LICENSURE

(1) through (3)(a) remain the same.

(i) management experience in health care, with or without supervision, from the administration, no more than ~~600~~ 200 points/year;

(ii) direct services experience providing health care services with direct patient contact, no more than ~~150~~ 100 points/year;

(iii) remains the same.

(b) Credit for educational training will be given as set forth in (i) through ~~(ii)~~(v) below. In the case where multiple degrees have been attained, credit shall be given for one degree only, according to the degree designated for credit by the license applicant.

~~(i)~~ (iii) ~~minimum of an~~ associate degree in a health care or business field equals ~~1,200~~ 600 points;

(i) bachelor degree or higher in a health care or business field equals 1,200 points;

(ii) remains the same but is renumbered (v).

(ii) bachelor degree in any other field equals 800 points;

(iv) associate degree in any other field equals 400 points;

(c) Training seminars/workshops/short courses in health care and business equals one point per approved clock hour;

(d) through (4) remain the same.

(5) The applicant must submit three statements of good moral character from individuals not related to the applicant.

AUTH: 37-1-131, 37-9-203, MCA
IMP: 37-9-203, 37-9-301, 37-9-304, MCA

REASON: The board acknowledges that most states require a bachelor's degree for licensure as a nursing home administrator. The board would like to increase the licensure requirements accordingly, but remains sensitive to the challenges Montana's rural communities face in recruiting licensees. Thus, the board is amending this rule by assigning higher point values to the higher education levels to reflect its support of the national trend towards requiring a bachelor's degree for licensure.

During a department assessment of all licensure boards' business processes, it was discovered that the board's application process failed to address the statutory requirement at 37-9-301, MCA, for applicants of good character. The board

determined it is reasonably necessary to add (5) to this rule and require that applicants submit three statements of good moral character to further implement the statute.

24.162.506 TEMPORARY PERMIT (1) remains the same.

(2) The temporary license shall be valid for 120 days or until the applicant passes the national examination, whichever comes first.

(3) Only one temporary license will be issued per applicant.

AUTH: 37-1-319, ~~37-9-201,~~ 37-9-203, MCA
IMP: 37-1-305, 37-9-203, 37-9-302, MCA

REASON: Following a business process analysis of all boards, department staff raised concerns about the board issuing temporary permits without parameters set for the length of time or termination date. The board is amending this rule now to specify that temporary permits are limited in duration and issued one per applicant.

The board is amending the authority and implementation cites to accurately reflect all statutes implemented through the rule and provide the complete sources of the board's rulemaking authority.

24.162.510 RECIPROCITY LICENSES (1) remains the same.

(a) that the applicant attained a passing scaled score, as determined by the ~~national association of boards of examiners for nursing home administrators~~ National Association of Boards of Examiners for Nursing Home Administrators on an examination prepared by the professional examination service or the national association of boards; and

(b) through (2) remain the same.

(3) The applicant must submit three statements of good moral character from individuals not related to the applicant.

AUTH: 37-1-131, ~~37-9-201,~~ 37-9-203, MCA
IMP: 37-1-304, 37-9-301, ~~37-9-303,~~ MCA

REASON: During a department assessment of all licensure boards' business processes, it was discovered that the board's reciprocity application process failed to address the statutory requirement at 37-9-301, MCA, for applicants of good character. The board determined it is reasonably necessary to add (3) to this rule and require that applicants submit three statements of good moral character to further implement the statute.

Authority and implementation cites are being amended to accurately reflect all statutes implemented through the rule, to provide the complete sources of the board's rulemaking authority, and to delete reference to a repealed statute.

24.162.2105 CONTINUING EDUCATION (1) All applicants for renewal of licenses and inactive registration shall have completed ~~a~~ continuing education (CE) ~~course~~ as a condition ~~to establish eligibility for~~ of renewal.

~~(2) All courses for continuing education obtained from a provider that is not on the board's preapproved list must be approved by the board based upon the relevance to current nursing home administrator issues.~~

~~(a) The board shall adopt policy guidelines for approval of continuing education courses.~~

~~(b) A list of the guidelines for approval must be provided to all new licensees and must be available from the board office and through electronic media.~~

~~(c) Licensees who attend a course not offered by a preapproved provider/sponsor shall submit the course for approval on the form prescribed by the board and accompanied by the appropriate fee. All courses must be submitted for approval by December 31 of the year in which the course was attended.~~

~~(d) A list of approved providers/sponsors and courses must be mailed to licensees with each renewal notice and must be available from the board office through the electronic media.~~

~~(3) The board may preapprove providers/sponsors of continuing education. Courses obtained from a preapproved provider/sponsor do not need to be submitted for approval. Courses sponsored by preapproved providers/sponsors that are germane to long-term care will be automatically accepted by the board.~~

~~(a) Applications for approval as a provider must be made on a form prescribed by the board.~~

~~(b) The board will require that the providers/sponsors demonstrate expertise in the areas of long-term care including accredited educational institutions, recognized professional or trade associations, or other legitimate organizational entities capable of conducting adult continuing education.~~

~~(c) The board shall annually review the list of preapproved providers/sponsors for assurance as to the quality and relevance of courses offered and the provider's compliance with the board's policies relative to preapproved providers.~~

~~(d) The board may grant continuing education credit to the licensees who have attended courses/programs that have been accepted by other state boards/associations of nursing home administrators.~~

~~(4) Twenty-five hours of continuing education will be required annually for renewal of a license or renewal of inactive registration.~~

~~(a) Up to 25 hours earned in excess of 25 hours in a calendar year may be carried over into the succeeding year.~~

~~(b) A licensee is exempt from the continuing education requirement the year of original licensure.~~

~~(c) The board will conduct continuing education audits. Those licensees selected shall submit proof of completion of continuing education courses. Licensees are responsible for maintaining their records of participation of continuing education and make them available upon request.~~

~~(d) One semester credit is equal to 15 continuing education hours, and 60 minutes of class time equals one continuing education hour.~~

~~(5) No more than 15 hours of college courses may be submitted for continuing education without prior approval of the board. These courses should contribute to the professional competence of the participant.~~

(2) Twenty hours of CE will be required annually for renewal of a license or renewal of an inactive registration.

(3) A licensee is exempt from the CE requirement the year of original licensure.

(4) The board/staff will not pre-approve CE programs or sponsors. It is the responsibility of the licensee to select quality programs that:

(a) contribute to the licensee's knowledge and professional competence;

(b) contain significant intellectual or practical content; and

(c) deal primarily with substantive nursing home issues as contained in state and federal mandates.

(5) A CE program means a class, institute, lecture, conference, workshop, cassette, videotape, internet or correspondence course or peer-reviewed publication of a journal article(s) or textbook(s) that meets the requirements of (4). Programs that promote a company, individual, or product are excluded.

(6) The board may grant CE hours to a licensee who attended courses or programs accepted by other state boards or associations of nursing home administrators, if the licensee demonstrates that the activity meets the requirements of (4).

(7) No more than 15 hours of college courses may be submitted for CE credit without prior approval of the board. These courses must comply with the requirements of (4).

(8) One semester credit is equal to 15 CE hours, and 60 minutes of class time is equal to one CE hour.

(9) All acceptable CE courses must issue a program or certificate of completion containing the following information:

(a) full name and qualifications of the presenter;

(b) title of the presentation attended;

(c) number of hours and date of each presentation attended;

(d) name of sponsor; and

(e) description of the presentation format.

(10) Licensees can earn up to a maximum of eight CE hours per year by teaching acceptable university or college courses.

(a) Acceptable courses are based on the following criteria:

(i) courses must be germane to the licensee's profession;

(ii) the licensee must be the instructor of the course; and

(iii) the course must be addressed to health professionals.

(b) The instructor will be awarded two CE hours for a one hour presentation.

(c) Instruction of any course may be submitted for CE credit only once.

(d) Instructors employed by universities and colleges will not receive CE hours in this section for conducting courses that are a part of the regular course offering of the institutions. This applies to courses that are offered in the evening or summer.

(11) The board will conduct random CE audits. Licensees selected for audit shall submit proof of completion of CE courses. Licensees are responsible for maintaining their CE records and making such records available upon board request.

AUTH: 37-1-131, 37-1-319, 37-9-201, 37-9-203, MCA
IMP: 37-1-306, 37-1-319, 37-9-203, ~~37-9-305,~~ MCA

REASON: The board is amending this rule by reorganizing and reformatting the rule text as the board determined that the current rule is poorly organized and confusing to licensees.

The board is also amending this rule to simplify the continuing education (CE) requirements and reporting processes. The board anticipates that the amendments will result in CE requirements that are more affordable, accessible, and less restrictive than the current requirements.

The board is amending this rule to eliminate board preapproval of CE providers. The board determined that the preapproval process is confusing and cumbersome for both licensees and the board. The board notes that late approval or denial of a provider often resulted in licensees scrambling to obtain CE prior to renewal. The new process places the responsibility on the licensee to select appropriate CE courses within the guidelines of the board.

Following amendment, licensees will only be required to complete 20 CE hours per year. The board concluded that reducing the CE hours from 25 to 20 aligns Montana's requirements with the national average. In addition, licensees will no longer be able to carry any CE hours forward from year to year. The board notes that the purpose of requiring CE is to ensure that licensees remain up-to-date on current trends and changes in health care and allowing carryover does not further this purpose.

The board is also amending this rule to allow licensees to obtain some CE through teaching relevant college courses. In response to requests from licensees, the board determined that it is reasonable to allow up to eight hours of CE annually from teaching.

Implementation cites are being amended to accurately reflect all statutes implemented through this rule.

4. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Board of Nursing Home Administrators, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or by e-mail to dlibsdnha@mt.gov, and must be received no later than 5:00 p.m., August 19, 2009.

5. An electronic copy of this Notice of Public Hearing is available through the department and board's site on the World Wide Web at www.nha.mt.gov. The department strives to make the electronic copy of this Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical

problems, and that technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

6. The board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies the person wishes to receive notices regarding all board administrative rulemaking proceedings or other administrative proceedings. The request must indicate whether e-mail or standard mail is preferred. Such written request may be sent or delivered to the Board of Nursing Home Administrators, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, faxed to the office at (406) 841-2305, e-mailed to dlibsdnha@mt.gov, or made by completing a request form at any rules hearing held by the agency.

7. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

8. Anne O'Leary, attorney, has been designated to preside over and conduct this hearing.

BOARD OF NURSING HOME ADMINISTRATORS
CARLA NEIMAN, CHAIRPERSON

/s/ DARCEE L. MOE
Darcee L. Moe
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State July 6, 2009

BEFORE THE BOARD OF PHARMACY
DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.174.301 definitions, 24.174.503 administration of vaccines, 24.174.510 prescriptions, 24.174.523 transmission of prescriptions, 24.174.601 objectives, 24.174.602 internship, 24.174.701 registration requirements, 24.174.703 pharmacy technician, 24.174.817 record keeping, 24.174.1002 registration conditions, 24.174.1114 emergency drug kit, 24.174.2102 and 24.174.2103 renewal, 24.174.2301 unprofessional conduct, and repeal of 24.174.1007 agent of records	)))))))))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On August 6, 2009, at 9:00 a.m., a public hearing will be held in room B-07, 301 South Park Avenue, Helena, Montana to consider the proposed amendment and repeal of the above-stated rules.

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Pharmacy (board) no later than 5:00 p.m., on July 31, 2009, to advise us of the nature of the accommodation that you need. Please contact Ronald J. Klein, Board of Pharmacy, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2371; Montana Relay 1 (800) 253-4091; TDD (406) 444-2978; facsimile (406) 841-2305; e-mail pharmacy@mt.gov.

3. The rules proposed to be amended provide as follows, stricken matter interlined, new matter underlined:

24.174.301 DEFINITIONS In addition to the terms defined in 37-7-101, MCA, the following definitions apply to the rules in this chapter.

(1) through (26) remain the same.

(27) "Pharmacist-in-charge" means a pharmacist licensed in Montana who accepts responsibility for the operation of a pharmacy in conformance with all laws and rules pertinent to the practice of pharmacy, who assures that the pharmacy and all pharmacy personnel working in the pharmacy have current and appropriate

licensure and certification, and who is personally in full and actual charge of such pharmacy.

(28) through (36) remain the same.

AUTH: 37-1-131, 37-7-201, 50-32-314, MCA
IMP: 37-7-102, 37-7-201, 37-7-301, 37-7-321, 37-7-406, 37-7-603, 37-7-604, 37-7-605, 50-32-314, MCA

REASON: The board determined it is reasonably necessary to amend this definition to address recent questions addressing the responsibility of pharmacists-in-charge regarding licensure. Although the board's intent has been for pharmacists-in-charge to ensure proper licensure of pharmacies and employees, the requirement was not previously set forth in rule.

24.174.503 ADMINISTRATION OF VACCINES BY PHARMACISTS (1) through (7) remain the same.

(8) The pharmacist must provide a certified true copy of the immunization certificate and CPR certification to the board for initial endorsement on their ~~pharmacy~~ pharmacist license.

(9) In order to maintain the immunization endorsement on their ~~pharmacy~~ pharmacist license, an immunization certified pharmacist must:

(a) through (10) remain the same.

AUTH: ~~37-7-101,~~ 37-7-201, MCA
IMP: 37-7-101, 37-7-201, MCA

REASON: The board is amending this rule to correct an inadvertent error discovered during the October 2008 meeting. Immunization endorsements are attached to pharmacist licenses, not pharmacy licenses. Authority cites are being amended to accurately reflect the statutory sources of the board's rulemaking authority.

24.174.510 PRESCRIPTION REQUIREMENTS (1) remains the same.

(2) "Brand name medically necessary" shall be handwritten (or printed if electronically generated) on the face of the prescription if it is medically necessary that an equivalent drug product not be selected.

(Note: Information presented in brackets [ ] represents institutional pharmacy requirements.)

AUTH: 37-7-201, MCA
IMP: 37-7-201, 37-7-505, MCA

REASON: It is reasonable and necessary to amend this rule to clarify that "brand name medically necessary" must be handwritten or printed on the prescription. The board determined that checking a box or signing on a specified line is not a reliable method to communicate this information because it is frequently done unintentionally by the prescriber. Many third party payers require that "brand name medically

necessary" be handwritten on the prescription for payment and audit pharmacies to assure compliance. The handwritten requirement will give pharmacists a tool to inform and educate prescribers on what is currently an industry standard.

Implementation cites are being amended to accurately reflect all statutes implemented through this rule.

24.174.523 TRANSMISSION OF PRESCRIPTIONS BY ELECTRONIC MEANS (1) through (4) remain the same.

(5) Computer-generated, electronically signed prescriptions that are handed directly to a patient or to a patient's agent must be authenticated by the prescriber by one of the following methods:

(a) the prescription must be hand signed with the actual signature of the prescriber; or

(b) a prescription that is electronically signed by the prescriber must include an additional security feature on the prescription that cannot be reproduced.

(i) It is the prescriber's responsibility to identify the security feature on the face of the prescription.

(ii) It is the prescriber's responsibility to indicate on the face of the prescription that the prescription is not valid without the security feature.

(5) remains the same but is renumbered (6).

AUTH: 37-7-201, 50-32-103, MCA
IMP: 37-7-102, 37-7-201, 50-32-208, MCA

REASON: The board is amending this rule to address the security of electronically generated prescriptions that are handed directly to patients rather than transmitted to a pharmacy by electronic means. The board has received requests to consider options other than hand signing to authenticate these electronically generated prescriptions. The board concluded that a method to authenticate these prescriptions is needed to ensure that the prescriptions have not been reproduced. This amendment provides the flexibility of an alternative to hand signing as long as the alternative is clearly marked on the prescription, such as, "prescription invalid if not stamped with a red seal" or "prescription not valid without watermark."

24.174.601 SUMMARY OF OBJECTIVES (1) ~~Internship training, using academic training as a foundation, provides a learning experience in real life situations that will result in a professional who is competent to practice pharmacy and render professional services on their own, without supervision at the time of licensure. The objectives shall be:~~

~~(a) a practically, accurately and safely trained intern;~~

~~(b) an ethically trained intern; and~~

~~(c) a legally trained intern~~ The practical experiences required prior to professional licensure shall be referred to as internship. The purpose of pharmacy internship is to provide an intern with the knowledge and practical experience necessary for professional licensure.

AUTH: 37-7-201, MCA

IMP: 37-7-201, MCA

REASON: The board determined it is reasonably necessary to amend this rule to align with national internship standards. Noting that this internship rule is outdated, the board is amending it to reflect what is happening in current national practice standards as promoted by the National Association of Boards of Pharmacy (NABP).

24.174.602 INTERNSHIP REQUIREMENTS (1) The experience required to obtain licensure as a pharmacist shall be that instruction period composed of computed time obtained under the supervision of the preceptor in an approved site. An intern may ~~not work alone and assume the responsibility of a registered pharmacist~~ practice only under the immediate personal supervision of a registered pharmacist.

(2) and (3) remain the same.

(4) The intern shall make such reports and certifications as required under the approved program and as required by the board.

(5) through (8) remain the same.

(9) ~~Only those students who have completed the first professional year (third year) of the pharmacy curriculum may begin their internship.~~ An intern shall be:

(a) a student currently enrolled in an accredited pharmacy program;

(b) a graduate of an accredited pharmacy program serving an internship; or

(c) a graduate of a pharmacy program located outside the United States of America which is not accredited and who has successfully passed equivalency examinations approved by the board.

(10) Intern registration based on enrollment in or graduation from an accredited pharmacy program shall expire not later than 12 months after the date of graduation or at the time of professional licensure, whichever comes first. Intern registration based on graduation from a pharmacy program located outside of the United States of America which is not accredited shall expire not later than 12 months after the date of issuance of the registration or at the time of professional licensure, whichever comes first.

(11) An intern registration may be issued to a student currently enrolled in an accredited pharmacy program at any time after they have completed 30 days of study, submitted a completed application to the board, and paid the required fee.

(10) and (11) remain the same but are renumbered (12) and (13).

~~(12)~~ (14) ~~An intern will be allowed six months after taking the NAPLEX examination to complete requirements for licensure. The time may be extended, subject to the approval of the board, if extenuating circumstances prohibit completion in the prescribed time~~ An intern registration may be extended, subject to approval by the board, upon application by the intern, if extenuating circumstances are present.

AUTH: 37-7-201, MCA
IMP: 37-7-201, MCA

REASON: The board is amending this rule to comport with current national standards as promoted by the National Association of Boards of Pharmacy (NABP).

The board notes that these standards are more directly reflective of current internship requirements on a national level. The board is amending language from negative, prohibitive language to more positive, directive language. The changes also help to adapt the rule to recognize the transition of pharmacy education from a baccalaureate program to a doctor of pharmacy program in many institutions, including the University of Montana. The board is also amending this rule to increase the time for pharmacy graduates to complete examination requirements. The board concluded that six months is often insufficient due to the number of interns that apply to the board for an extension of this time.

24.174.701 REGISTRATION REQUIREMENTS (1) and (2) remain the same.

(3) The permit to practice as a technician-in-training shall be valid for a period of not longer than 18 months~~, and may not be renewed~~. A technician-in-training applicant who has not passed the Pharmacy Technician Certification Board (PTCB), ExCPT, or other board-approved certifying exam within the 18 months due to extenuating circumstances may file a written request to the board for an extension of his or her technician-in-training license. The board will then determine when the license will expire. A technician-in-training whose license has expired but who did not pass the requisite exam may not apply for a technician-in-training license a second time.

(4) Working as a technician-in-training with an expired license is cause for disciplinary action against the licensee.

AUTH: 37-7-201, MCA
IMP: 37-7-201, MCA

REASON: It is reasonably necessary to amend this rule to clarify that technician-in-training permits are not renewable and that licensees cannot get around this by continuing to reapply once the 18-month permit period has passed. The board is amending the process for extending permit length to address numerous requests by technicians-in-training who have not passed their exam yet. The board concluded that an extension would benefit technicians-in-training who, due to particular circumstances, were not able to take or pass the exam, but wanted to continue to work.

The board notes that a large number of extension requests were submitted after the 18-month permit deadline. Therefore, the board is also amending this rule to clarify that the board considers anyone who practices past the deadline to be practicing without a valid and current license which may result in disciplinary action by the board.

24.174.703 USE OF PHARMACY TECHNICIAN (1) through (4) remain the same.

(5) All pharmacy technician licenses and technician-in-training permits must be conspicuously displayed at all times in the place of business.

AUTH: 37-7-201, MCA

IMP: 37-7-101, 37-7-201, 37-7-301, 37-7-307, MCA

REASON: The board is amending this rule to require the posting of technician licenses to reduce the number of technicians working with expired licenses and to make it easier for the pharmacy inspector to check licenses during inspections. The board concluded that it is important for the public to have knowledge of the registered pharmacy technicians as well as the pharmacists in a practice and therefore all licenses should be posted for public view.

24.174.817 AUTOMATED RECORD KEEPING SYSTEMS (1) through (1)(b)(i) remain the same.

(ii) provide a printout of each day's prescription information. That printout shall be verified, dated, and signed by the individual pharmacist verifying that the information indicated is correct and then sign this document in the same manner as signing a check or legal document (e.g., J. H. Smith, or John H. Smith). Such printout must be maintained at least two years from the date of last dispensing. ; or

(iii) utilize a software system which requires a unique log in for each function such that it can be easily and accurately determined who performed every function within the prescription dispensing process. The records must be readily accessible for viewing or printing at the request of the board.

(c) and (d) remain the same.

AUTH: 37-7-201, MCA
IMP: 37-7-201, MCA

REASON: The board determined it is reasonable and necessary to amend this rule to reflect the advancements in record-keeping computer software that provides the highest level of accuracy and real time information on individuals performing each step of the prescription filling process. The board is amending this rule to allow software systems in pharmacies that document the accountability of the pharmacists involved in and/or supervising the dispensing process including systems that require a biometric log on and off for each step in the prescription process.

24.174.1002 CONDITIONS OF REGISTRATION (1) remains the same.

(a) be a legal entity registered and in good standing with the Montana Secretary of State with a registered agent in Montana for service of process designated;

(b) through (f) remain the same.

AUTH: 37-7-201, 37-7-712, MCA
IMP: 2-18-704, 37-7-701, 37-7-702, 37-7-703, 37-7-704, 37-7-706, MCA

REASON: The board is amending this rule to maintain the requirement that mail order pharmacies designate a registered agent in Montana. The board is repealing ARM 24.174.1007, the rule that currently contains this requirement, in this notice.

Authority and implementation cites are being amended to accurately reflect

the statutes implemented through the rule and to provide the complete sources of the board's rulemaking authority.

24.174.1114 USE OF EMERGENCY DRUG KITS IN CERTAIN INSTITUTIONAL FACILITIES (1) and (1)(a) remain the same.

(b) the supplying pharmacist and the designated practitioner or appropriate committee of the institutional facility shall jointly determine the identity and quantity of drugs to be included in the kit. Such drugs shall then be approved in advance of placement in the emergency kit by the board; unless such drugs are included on a general list of drugs previously approved by the board for use in emergency kits;

(c) the kit must be locked and stored in a secure area to prevent unauthorized access and to ensure a proper storage environment for the drugs contained therein. The kit shall be secured with a seal to be of such a nature that it can be easily identified if it has been broken;

(d) through (2) remain the same.

(3) ~~The supplying pharmacist shall be notified of any entry into the kit. The supplying pharmacist shall have a mechanism defined in policy to restock and reseal the kit within a reasonable time so as to prevent risk of harm to patients.~~ Upon notice of any entry into the kit, the supplying pharmacist or another pharmacist designated by the supplying pharmacist shall restock and refill the kit, reseal the kit, and update the drug listing on the exterior of the kit within 72 hours.

(4) and (5) remain the same.

AUTH: 37-7-201, MCA
IMP: 37-7-201, MCA

REASON: The board is amending this rule regarding use of emergency drug kits in institutional facilities. The board concluded that the current requirements are vague, and allow for emergency drug kits of unlimited size which are not true emergency kits. Further, the board's pharmacy inspector has encountered apparent instances of abuse regarding these kits. The proposed amendments will allow the board to adopt a list of drugs which are truly used in emergency situations for use in emergency drug kits.

This rule was designed to limit access to the drugs only to authorized individuals and include a provision that the kit remain sealed. The purpose of the seal is to guarantee the integrity of the kit so the practitioner can be assured of a complete inventory of drugs in an emergency situation. The drugs in an emergency kit amount to an extension of the pharmacy. No drug may be dispensed without a prescription and a prescription must be issued to account for the reduction in inventory. The board is further amending this rule to clarify the nature of the required seal which had not been addressed previously, and specify that emergency kits must be resealed timely following every entry.

24.174.2102 PHARMACY TECHNICIAN - RENEWAL (1) remains the same.

(2) To assure the continuing competence of a pharmacy technician, ~~proof of continued certification will be required~~ in order to renew a license, the pharmacy

technician must be in compliance with all certification requirements at the time of renewal.

AUTH: 37-7-201, MCA
IMP: 37-1-141, 37-7-201, MCA

REASON: It is reasonably necessary to amend this rule to delete the requirement of proof of certification as it conflicts with 37-1-131, MCA. The requirement regarding meeting the certification requirements has replaced that language and is in accordance with statute. Implementation cites are being amended to accurately reflect all statutes implemented through the rule.

24.174.2103 RENEWALS (1) and (2) remain the same.

~~(3) The annual renewal notice shall be returned to the board with the appropriate fee and a representation of having satisfactorily completed continuing education requirements signed by the licensee. Incomplete renewal applications will not be processed and will be returned to the applicant.~~

~~(a)~~ (3) The board shall randomly select submitted renewal notice forms for audit and verification of the ~~approved~~ continuing education ~~programs listed~~ requirements. It will be the responsibility of each pharmacist to maintain his or her own records of attendance or completion and make ~~them~~ such documents available upon request.

(a) The board shall randomly select submitted renewal notice forms for audit and verification of current pharmacy technician certification from a board-approved certifying entity. It shall be the responsibility of each pharmacy technician to maintain his or her current pharmacy technician certification and make such certification available upon request.

(4) remains the same.

AUTH: 37-1-319, 37-7-201, MCA
IMP: 37-1-131, 37-1-141, 37-1-306, 37-7-201, MCA

REASON: The board determined it is reasonably necessary to amend this rule to delete (3), which unnecessarily repeats (2), and to renumber the rule accordingly.

The board is also amending the rule to specify that the board will conduct random audits of pharmacy technician renewals. Continued certification is a requirement for pharmacy technician registration and the board concluded that auditing is necessary to ensure the continued competence of pharmacy technicians.

Authority and implementation cites are being amended to accurately reflect all statutes implemented through the rule and to provide the complete sources of the board's rulemaking authority.

24.174.2301 UNPROFESSIONAL CONDUCT (1) through (1)(t) remain the same.

(u) failure to comply with an agreement the licensee has entered into with the impaired pharmacist program~~.~~; or

(v) engaging in the practice of pharmacy or assisting in the practice of pharmacy when the licensee's license has been suspended or revoked, or is expired or terminated.

AUTH: 37-1-319, 37-7-201, MCA
IMP: 37-1-316, 37-7-201, MCA

REASON: It is necessary to amend the rules on unprofessional conduct because it is unlawful to engage in the practice of pharmacy without a current, valid license. The board is adding (1)(v) to delineate this unlicensed pharmacy practice as unprofessional conduct. Implementation cites are being amended to accurately reflect all statutes implemented through the rule.

4. The rule proposed to be repealed is as follows:

24.174.1007 AGENT OF RECORD found at ARM page 24-19745.

AUTH: 37-7-712, MCA
IMP: 37-7-703, MCA

REASON: It is reasonably necessary to repeal this rule addressing agent of record to eliminate inaccurate terminology and unnecessary and improper processes. The requirement to designate an agent of record in Montana is being added to ARM 24.174.1002 in this notice.

5. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Board of Pharmacy, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or by e-mail to pharmacy@mt.gov, and must be received no later than 5:00 p.m., August 14, 2009.

6. An electronic copy of this Notice of Public Hearing is available through the department and board site on the World Wide Web at www.pharmacy.mt.gov. The department strives to make the electronic copy of this Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

7. The board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies the person

wishes to receive notices regarding all board administrative rulemaking proceedings or other administrative proceedings. The request must indicate whether e-mail or standard mail is preferred. Such written request may be sent or delivered to the Board of Pharmacy, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, faxed to the office at (406) 841-2305, e-mailed to pharmacy@mt.gov, or made by completing a request form at any rules hearing held by the agency.

8. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

9. Michael L. Fanning, attorney, has been designated to preside over and conduct this hearing.

BOARD OF PHARMACY
WILLIAM BURTON, RPH, PRESIDENT

/s/ DARCEE L. MOE
Darcee L. Moe
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State July 6, 2009

BEFORE THE BOARD OF RADIOLOGIC TECHNOLOGISTS
DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.204.501 permit application types, 24.204.504 practice limitations, 24.204.507 course requirements, 24.204.511 permit examinations, 24.204.607 code of ethics, and 24.204.2301 unprofessional conduct	)))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On August 7, 2009, at 10:00 a.m., a public hearing will be held in room B-07, 301 South Park Avenue, Helena, Montana to consider the proposed amendment of the above-stated rules.

2. The Department of Labor and Industry (department) will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Radiologic Technologists (board) no later than 5:00 p.m., on July 31, 2009, to advise us of the nature of the accommodation that you need. Please contact Helena Lee, Board of Radiologic Technologists, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2385; Montana Relay 1 (800) 253-4091; TDD (406) 444-2978; facsimile (406) 841-2305; e-mail dlibsdrts@mt.gov.

3. The rules proposed to be amended provide as follows, stricken matter interlined, new matter underlined:

24.204.501 LIMITED PERMIT APPLICATION - TYPES (1) and (2) remain the same.

(a) graduates of ~~the 88-hour~~ a minimum 104-hour board approved course set forth in ARM 24.204.507; or

(b) through (4) remain the same.

(5) Upon passage of the examination, ~~the license applicant shall submit the appropriate original license fee~~ the license is issued. Applicants who fail the examination must make a request to the board to be registered for the examination again and pay the examination fee.

AUTH: 37-1-131, 37-14-202, 37-14-306, MCA
IMP: 37-14-305, 37-14-306, MCA

REASON: The board determined it is reasonably necessary to increase the educational requirements for limited permit applicants throughout the rules to keep pace with national trends. Pending federal legislation requires a bachelor's degree

for limited permit holders. While acknowledging the potential federal changes, the board concluded that a bachelor's degree is excessive and unnecessary for safe provision of functions at this entry level of practice.

The board concluded that requiring a minimum 104-hour course will ensure that permit holders have demonstrated competency in high quality imaging procedures and further protect the public health, welfare and safety. The board is amending ARM 24.204.501, 24.204.504, 24.204.507, and 24.204.511 accordingly. The board is amending (5) to address questions from applicants by clarifying the timing of license issuance and the necessary steps to take if an applicant fails an examination. Implementation cites are being amended to accurately reflect all statutes implemented through this rule.

24.204.504 PERMITS - PRACTICE LIMITATIONS (1) and (2) remain the same.

(3) Limited permit holders who completed the ~~88-hour~~ 104-hour training are not authorized or permitted to perform fluoroscopy procedures due to the difficulty in monitoring, limiting, and controlling the accumulative doses of ionizing radiation.

(4) through (4)(d) remain the same.

(5) If a student of a radiologic technologist program accredited by a mechanism recognized by the ~~ARRT~~ American Registry of Radiologic Technologists (ARRT) has completed the first two semesters of the program or its equivalent, as determined by the board, and has become a limited permit holder, that person may perform procedures while operating portable fluoroscopy equipment and may be compensated as long as the student is not performing procedures for course credit and has completed the clinical time requirements.

AUTH: 37-1-131, 37-14-202, MCA
IMP: 37-14-301, 37-14-306, MCA

REASON: The board is amending this rule to clarify when students may be compensated for performing radiologic procedures. The board concluded the amendment is necessary to address numerous questions received at the board office on this issue.

24.204.507 COURSE REQUIREMENTS FOR LIMITED PERMIT APPLICANTS (1) Course providers shall receive board approval prior to offering the courses outlined below and shall submit a request for reapproval every two years thereafter. The provider shall submit for the board's review, a course outline, agenda and the identification and qualifications of all instructors. Board approved courses must meet American Registry of Radiologic Technologists (ARRT) educational standards for limited permit holders.

(a) Courses that meet the requirements of this rule shall be board approved.

(b) All instructors shall be ARRT certified or licensed permit holders in the state of Montana. Approved course providers, instructors, or designees with five years experience include: radiologic technologists, limited permit holders, radiologic practitioner assistants/radiologist assistants, podiatrists, radiologists, and chiropractors.

(2) The course shall be ~~40~~ 56 hours in length and consist of the following:

(a) fundamentals of radiobiology~~,~~;

(b) imaging equipment~~,~~;

(c) fundamentals of radiation protection~~,~~;

(d) fundamentals of x-ray physics~~,~~;

(e) radiographic technique and principles of radiographic exposure~~,~~;

(f) darkroom procedures~~,~~;

(g) interrelationship of the radiographic chain~~,~~ (i.e. technique vs. darkroom procedures)~~,~~;

(h) adverse contrast reaction~~.~~;

(i) medical, legal and ethical - four hours;

(j) radiation safety - eight hours; and

(k) image production and evaluation - film critique - four hours.

(3) ~~An~~ Additional ~~course~~ courses and clinical competencies to include anatomy, physiology, positioning, pathology, x-ray technique, and proper handling of trauma patients, shall be required for the applicant to qualify for examination in each of the specified limited x-ray procedures. Course length and clinical competencies ~~is~~ specified for each limited x-ray procedure~~.~~ are:

(a) chest - four hours, and passing competencies - ten hours actual;

(b) extremities - eight hours, and passing upper extremities competencies - five hours actual and passing lower extremities competencies - five hours actual;

(c) spine - eight hours, and passing competencies - ten hours actual;

(d) skull - eight hours, and passing competencies - ten hours, of which five may be simulated;

(e) abdomen - four hours, and passing competencies - ten hours actual;

(f) GI tract and associated overhead films - eight hours, and passing competencies - ten hours, all of which may be simulated; and

(g) positioning - eight hours, and passing competencies - ten hours actual.

(4) Demonstration of competence includes: requisition evaluation, patient assessment, room preparation, patient management, equipment operation, technique selection, position skills, radiation safety, image processing, and image evaluation.

(5) Demonstration of clinical competence means that the approved course providers, instructors, or designee have observed the limited permit applicant performing the procedure, and that the applicant performed the procedure independently, consistently, and effectively. Applicants must demonstrate competence as outlined in (3) in the categories the applicant is requesting to be authorized to take x-ray procedures in.

(6) A board approved checklist for demonstration of competencies will be included with the downloadable application.

(7) At no time may the applicant initiate ionizing exposure during performance of the clinical competencies.

~~(4)~~ (8) ~~A portion of the required classroom hours may be substituted by a verifiable~~ Verifiable correspondence or on-line ~~course~~ course(s) are subject to board approval. ~~The portion of required classroom hours completed by correspondence may not exceed 40 percent of the total hours required for examination(s) requested by the applicant.~~

~~(5)~~ (9) To be exempt under 37-14-301, MCA, from obtaining a permit, ~~an eight-hour course in darkroom procedures shall be completed by~~ any person performing only darkroom procedures must complete an eight-hour course in darkroom procedures.

AUTH: 37-1-131, 37-14-202, MCA
IMP: 37-14-301, 37-14-306, MCA

REASON: The board determined it is reasonably necessary to increase the educational requirement for limited permit applicants throughout the rules to keep pace with national trends. The board also concluded that requiring a minimum 104-hour course in accordance with the American Registry of Radiologic Technologists' educational standards for limited permit holders will ensure that permit holders have demonstrated competency in high quality imaging procedures and further protect the public health, welfare and safety. Therefore, the board is amending this rule to specifically delineate the increased educational standards regarding minimum 104-hour course requirements and acceptable demonstration of an applicant's clinical competencies.

The board is adding (7) to this rule to specify the board's intention that applicants are not allowed to initiate ionizing exposure during performance of their clinical competencies. The board determined that because an applicant has not passed the national exam at this point and is not licensed, it is reasonably necessary to set forth this prohibition for clarification.

The board is also amending this rule to allow limited permit applicants to obtain some coursework on-line. The board determined that some excellent educational offerings are available on-line and the options for applicants should be expanded.

24.204.511 PERMIT EXAMINATIONS (1) All limited permit applicants shall take and pass the ~~ARRT~~ American Registry of Radiologic Technologists (ARRT) limited scope core examination.

(a) through (vii) remain the same.

(2) In addition to the ARRT limited scope core examination, ~~88-hour~~ 104-hour course graduates shall complete a module examination for selected anatomic regions in which the applicant desires to be permitted.

(a) through (5) remain the same.

(6) Applicants for a~~n 88-hour~~ 104-hour course permit who fail any portion of the ARRT limited scope examination (core or any module examination) on two attempts shall be required to successfully complete additional coursework in the failed area(s) of the examination before being allowed to retake the failed portion(s) of the examination a third time.

(a) On a case-by-case hardship basis, the board may allow an unsuccessful applicant to receive tutoring in lieu of the additional ~~course work~~ coursework. A tutor must have at least five years experience as a licensed radiologic technologist and possess a current ARRT card or be a limited permit holder with five years experience and a current limited permit license. Limited permit holders cannot tutor radiologic technologists. The tutor must submit for board approval the tutor's

qualifications and an outline of the materials and topics to be studied by the applicant under the instruction of the tutor. The applicant is responsible for paying all costs associated with the tutorial.

(7) through (10) remain the same.

AUTH: 37-1-131, 37-14-202, MCA
IMP: 37-1-131, 37-14-306, MCA

REASON: The board is amending this rule to clarify that limited permit holders may qualify to tutor unsuccessful limited permit applicants. The board concluded that since a limited permit holder may be the designee for the demonstrated clinical competency, an experienced limited permit holder would also qualify to be a tutor for other limited permit applicants.

24.204.607 CODE OF ETHICS (1) The board adopts and incorporates by reference the ~~July 2003~~ August 1, 2008 edition of the code of ethics ~~adopted~~ by the ~~ARRT~~ American Registry of Radiologic Technologists (ARRT).

(2) through (4)(g) remain the same.

AUTH: 37-1-131, 37-14-202, 37-14-313, MCA
IMP: 37-1-131, 37-14-313, MCA

REASON: The board is amending this rule to update the reference to the most current version of the ARRT code of ethics as adopted and incorporated by the board. Implementation cites are being amended to accurately reflect all statutes implemented through this rule.

24.204.2301 UNPROFESSIONAL CONDUCT (1) through (1)(f) remain the same.

(g) failing to comply with the provision of Title 37, chapter 14, MCA, or any rule promulgated thereunder; ~~and~~

(h) presenting a tampered or fraudulently produced American Registry of Radiologic ~~Technologist~~ Technologists (ARRT) pocket card and/or certificate for application or renewal purposes~~.~~; and

(i) performing a radiologic technologist procedure (other than a screening mammogram) without an order from a licensed provider.

AUTH: 37-1-131, 37-1-319, 37-14-202, MCA
IMP: 37-1-131, ~~37-1-307,~~ 37-1-316, MCA

REASON: The board determined it is reasonably necessary to amend this rule by adding to the actions considered by the board as unprofessional conduct. The board, through its screening panel, recently reviewed two complaints involving licensees performing x-rays without an order. To better protect public health, safety, and welfare, the board is amending this rule to enable the board to adequately address complaints of this nature in the future.

Authority and implementation cites are being amended to accurately reflect all statutes implemented through the rule and provide the complete sources of the board's rulemaking authority.

4. Concerned persons may present their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Board of Radiologic Technologists, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or by e-mail to dlibsdrts@mt.gov, and must be received no later than 5:00 p.m., August 17, 2009.

5. An electronic copy of this Notice of Public Hearing is available through the department and board's site on the World Wide Web at www.radiology.mt.gov. The department strives to make the electronic copy of this Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

6. The Board of Radiologic Technologists maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this board. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies the person wishes to receive notices regarding all board administrative rulemaking proceedings or other administrative proceedings. The request must indicate whether e-mail or standard mail is preferred. Such written request may be sent or delivered to the Board of Radiologic Technologists, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, faxed to the office at (406) 841-2305, e-mailed to dlibsdrts@mt.gov, or made by completing a request form at any rules hearing held by the agency.

7. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

8. Anne O'Leary, attorney, has been designated to preside over and conduct this hearing.

BOARD OF RADIOLOGIC
TECHNOLOGISTS
CHARLES MCCUBBINS, CHAIRPERSON

/s/ DARCEE L. MOE
Darcee L. Moe
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State July 6, 2009

BEFORE THE DEPARTMENT OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 32.6.712, pertaining to food safety and inspection service (meat, poultry)	)))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On August 17, 2009, the Department of Livestock proposes to amend the above-stated rule.

2. The Department of Livestock will make reasonable accommodations for persons with disabilities who wish to participate in the rulemaking process and need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Livestock no later than 5:00 p.m. on August 17, 2009 to advise us of the nature of the accommodation that you need. Please contact Christian Mackay, 301 N. Roberts St., Room 308, P.O. Box 202001, Helena, MT 59620-2001; telephone (406) 444-9321; TTD number 1-800-253-4091; fax (406) 444-1929; e-mail cmackay@mt.gov.

3. The rule as proposed to be amended provides as follows, stricken matter interlined, new matter underlined:

32.6.712 FOOD SAFETY AND INSPECTION SERVICE (MEAT, POULTRY)

(1) and (2) remain the same.

(3) The Department of Livestock incorporates by reference the following as they were amended effective ~~October 1, 2007~~ April 17, 2009.

(a) through (6) remain the same.

AUTH: 81-2-102, 81-9-220, MCA
IMP: 81-2-102, 81-9-217, 81-9-220, MCA

REASON: The proposed amendment to ARM 32.6.712 is necessary for the Montana State Meat and Poultry Inspection program to maintain its "equal to" status. The proposed amendment was brought to Department of Livestock's attention by the review staff with USDA FSIS. The proposed amendment in (3) will adopt the 2009 amendments to 9 CFR 309 dealing with nonambulatory disabled cattle.

4. Concerned persons may submit their data, views, or arguments concerning the proposed action in writing to Christian Mackay, 301 N. Roberts St., Room 308, P.O. Box 202001, Helena, MT 59620-2001, by faxing to (406) 444-1929, or by e-mailing to cmackay@mt.gov to be received no later than 5:00 p.m., August 17, 2009.

5. If persons who are directly affected by the proposed action wish to express their data, views, and arguments orally or in writing at a public hearing, they must make a written request for a hearing and submit this request along with any written comments they have to the same address as above. The written request for hearing must be received no later than 5:00 p.m. August 17, 2009.

6. If the department receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the appropriate administrative rule review committee of the Legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a public hearing will be held at a later date. Notice of the public hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected have been determined to be more than 25, based upon the population of the state.

7. An electronic copy of this proposal notice is available through the department's site at www.liv.mt.gov.

8. The Montana Department of Livestock maintains a list of interested persons who wish to receive notice of rulemaking actions proposed by this department. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies the area of interest that the person wishes to receive notices regarding. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to Christian Mackay, 301 N. Roberts St., Room 308, P.O. Box 202001, Helena, MT 59620-2001; faxed to (406) 444-1929 "attention Christian Mackay"; or e-mailed to cmackay@mt.gov. Request forms may also be completed at any rules hearing held by the department.

9. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

DEPARTMENT OF LIVESTOCK

BY: /s/ Christian Mackay
Christian Mackay
Executive Officer
Board of Livestock
Department of Livestock

BY: /s/ George H. Harris
George H. Harris
Rule Reviewer

Certified to the Secretary of State July 6, 2009.

BEFORE THE BOARD OF HORSE RACING
DEPARTMENT OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 32.28.202 and 32.28.801 pertaining to uncoupling horses for wagering purposes	)))))	NOTICE OF PROPOSED AMENDMENT NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On August 27, 2009, the Board of Horse Racing proposes to amend the above-stated rules.

2. The Board of Horse Racing will make reasonable accommodations for persons with disabilities who wish to participate in the rulemaking process and need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Horse Racing no later than 5:00 p.m. on July 30, 2009 to advise us of the nature of the accommodation that you need. Please contact Sherry Rust, P.O. Box 200512, Helena, MT 59620-0512; telephone (406) 444-9321; TTD number 1-800-253-4091; fax (406) 444-4305; e-mail srust@mt.gov.

3. The rules as proposed to be amended provide as follows, new matter underlined, deleted matter interlined:

32.28.202 DEFINITIONS (1) through (14)(a) remain the same.

(b) for purposes of simulcast only, two or more horses which are entered in a race by the same owner or trained by the same trainer.

(15) through (52) remain the same.

AUTH: 23-4-104, 23-4-202, MCA
IMP: 23-4-101, 23-4-104, 23-4-202, MCA

REASON: The rule is amended to state that horses will not be coupled for live races.

32.28.801 GENERAL REQUIREMENTS (1) through (9) remain the same.

(10) When six horses are entered in a Montana bred race under six separate ~~interests~~ entries, such race shall be considered filled and shall be run. If a race is cancelled through a lack of that number of entries, the names of all horses entered in such cancelled race shall be immediately posted by the racing secretary. No race shall be cancelled without the approval of the stewards.

(11) through (35)(a) remain the same.

(b) ~~The stewards shall have the discretion to split trainer entries, if the entries have different owners, for the purpose of wagering.~~ Multiple horses owned by the

same racing interests shall be uncoupled in overnight races and stakes races for wagering purposes.

(c) ~~Lease arrangements shall reflect both lessor's (owner) and lessee's name in the racing program, and horses or mules showing the same or partially the same ownership (whether individually or through a partnership or corporation) shall be deemed a hard entry.~~ An owner may enter multiple horses in stakes races. Stakes preferences and conditions will be used to determine eligibility in stakes races.

(36) through (65) remain the same.

AUTH: 23-4-104, 23-4-202, MCA
IMP: 23-4-104, 23-4-202, MCA

REASON: The rule amendment corrects an outdated rule that addressed a perceived conflict. The rule has been changed in most other racing states to increase betting opportunities and to preserve racing fields. The racing stewards will address any actual conflicts resulting from multiple horses under one owner or trainer.

4. Concerned persons may submit their data, views, or arguments concerning the proposed action in writing to Board of Horse Racing, Attn. Ryan Sherman, P.O. Box 200512, Helena, MT 59620-0512, by faxing to (406) 444-4305, or by e-mailing to RSherman@mt.gov to be received no later than 5:00 p.m., August 13, 2009.

5. If persons who are directly affected by the proposed action wish to express their data, views, or arguments orally or in writing at a public hearing, they must make written request for a hearing and submit this request along with any written comments to Ryan Sherman at the above address no later than 5:00 p.m., August 13, 2009.

6. If the agency receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of the persons directly affected by the proposed action; from the appropriate administrative rule review committee of the Legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected has been determined to be 100 persons based on 1000 licensees in Montana.

7. An electronic copy of this proposal notice is available through the department's web site at www.liv.mt.gov.

8. The Board of Horse Racing maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-

mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to Ryan Sherman at Montana Board of Horse Racing, P.O. Box 200512, Helena, MT 59620-0512, by faxing to (406) 444-4305, or by e-mailing to RSherman@mt.gov, or may be made by completing a request form at any rules hearing held by the department.

9. An electronic copy of this Proposal Notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of this Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

10. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

/s/ Sherry K Meador
Sherry K Meador
Rule Reviewer

/s/ Christian Mackay
Christian Mackay
Executive Officer
Department of Livestock

Certified to the Secretary of State July 6, 2009.

BEFORE THE DEPARTMENT OF NATURAL RESOURCES
AND CONSERVATION OF THE STATE OF MONTANA

In the matter of the amendment of ARM 36.10.129, Wildland-Urban Interface, and the adoption of New Rule I regarding guidelines for development within the wildland-urban interface	))))))	NOTICE OF PUBLIC HEARINGS ON PROPOSED AMENDMENT AND ADOPTION

To: All Concerned Persons

1. The Department of Natural Resources and Conservation will hold three public hearings at 1:00 p.m. on the following dates: August 11, 2009, at the Lockwood Rural Fire Department Conference Room, 3329 Driftwood Lane, Billings, Montana; August 12, 2009, in the Bannack Conference Room at DNRC Headquarters at 1625 Eleventh Avenue, Helena, Montana; and on August 13, 2009, at the Department of Fish, Wildlife, and Parks, Region 2 Headquarters, 3201 Spurgin Road, Missoula, Montana, to consider the amendment and adoption of the above-stated rules.

2. The department will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the agency no later than 5:00 p.m. on August 4, 2009, to advise the department of the nature of the accommodation that you need. Please contact Pat Cross, Fire Prevention Specialist, Department of Natural Resources and Conservation Fire and Aviation Management Bureau, 2705 Spurgin Road, Missoula, MT 59804-3199; telephone (406) 542-4251, fax (406) 542-4242, e-mail pcross@mt.gov.

3. The rule as proposed to be amended provides as follows, stricken matter interlined, new matter underlined:

36.10.129 WILDLAND~~/~~-URBAN INTERFACE (1) County governments without ~~subdivision wildfire protection~~ standards related to development in the wildland-urban interface (WUI) are encouraged to establish standards ~~for all new subdivisions~~ by ~~January~~ October 1, 20~~0~~10.

(2) The ~~Fire Protection~~ Guidelines for Development within the Wildland~~-/Residential~~ Urban Interface ~~Development,~~ (DNRC~~DSL/DOJ~~, 1993~~2009~~)~~,~~ is~~ are available for use to assist counties in the development of standards.

(3) Counties that do not adopt the Guidelines for Development within the Wildland-Urban Interface by October 1, 2010, will not be eligible to receive grants or funding assistance from the department for purposes of development in the wildland-urban interface.

AUTH: 76-13-104, MCA
IMP: 76-13-104, MCA

REASONABLE NECESSITY: The amendments are meant to update recent developments in the knowledge associated with development in the wildland-urban interface, and to comply with 76-13-104(8), MCA, which requires the Montana Department of Natural Resources and Conservation to adopt administrative rules addressing development within the wildland-urban interface.

4. The rule proposed to be adopted provides as follows:

NEW RULE I WILDLAND-URBAN INTERFACE DEVELOPMENT GUIDELINES (1) The department adopts and incorporates by reference the Guidelines for Development within the Wildland-Urban Interface (DNRC 2009), which sets forth guidelines that counties may adopt for purposes of development within the wildland-urban interface. A copy of the Guidelines for Development Within the Wildland-Urban Interface (DNRC 2009) may be obtained from the Montana Department of Natural Resources and Conservation, 1625 Eleventh Avenue, Helena, Montana 59620.

AUTH: 76-13-104, MCA
IMP: 76-13-104, MCA

REASONABLE NECESSITY: New Rule I is meant to update recent developments in the knowledge associated with development in the wildland-urban interface. New Rule I is also meant to comply with 76-13-104(8), MCA, which requires the Montana Department of Natural Resources and Conservation to adopt administrative rules addressing development within the wildland-urban interface.

5. Concerned persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Pat Cross, Fire Prevention Specialist, Department of Natural Resources and Conservation, 2705 Spurgin Road, Missoula, MT 59804-3199; telephone (406) 542-4251; fax (406) 542-4241; or e-mailed to pcross@mt.gov, and must be received no later than 5:00 p.m. on August 20, 2008.

6. Mark Phares, Agency Counsel for the Department of Natural Resources and Conservation Forestry Division, 2705 Spurgin Road, Missoula, MT 59804 has been designated to preside over and conduct the public hearings.

7. An electronic copy of this Notice of Public Hearings on Proposed Amendment and Adoption is available through the department's web site at http://www.dnrc.mt.gov. The department strives to make the electronic copy of this Notice of Public Hearing on Proposed Amendment and Adoption conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered.

8. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding conservation districts and resource development, forestry, oil and gas conservation, trust land management, water resources, or a combination thereof. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be sent or delivered to the contact person in 6 above or may be made by completing a request form at any rules hearing held by the department.

9. The bill sponsor contact requirements of 2-4-302, MCA, apply and have been fulfilled. The bill sponsor was contacted by regular mail on November 21, 2007.

DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION

/s/ Mary Sexton
MARY SEXTON
Director
Natural Resources and Conservation

/s/ Mark Phares
MARK PHARES
Rule Reviewer

Certified to the Secretary of State on July 6, 2009.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of New Rule I - CLXVIII, amendment of 37.5.117, 37.5.304, 37.95.127, 37.95.227, 37.106.2506, 37.111.104, 37.111.123, 37.111.305, 37.111.339, 37.111.504, 37.111.523, and repeal of 37.111.1001, 37.111.1002, 37.111.1003, 37.111.1010, 37.111.1011, 37.111.1012, 37.111.1013, 37.111.1021, 37.111.1022, 37.111.1023, 37.111.1024, 37.111.1025, 37.111.1101, 37.111.1102, 37.111.1105, 37.111.1112, 37.111.1113, 37.111.1114, 37.111.1115, 37.111.1130, 37.111.1131, 37.111.1132, 37.111.1133, 37.111.1138, 37.111.1139, 37.111.1140, 37.111.1141, 37.111.1142, 37.111.1143, 37.111.1147, 37.111.1148, 37.111.1149, 37.111.1150, 37.111.1151, 37.111.1152, 37.111.1153, 37.111.1154, 37.111.1155, 37.111.1156, 37.111.1158, 37.111.1159, 37.111.1160, and 37.111.1161 pertaining to swimming pools, spas, and other water features

NOTICE OF SECOND PUBLIC HEARING AND EXTENSION OF COMMENT PERIOD ON PROPOSED ADOPTION, AMENDMENT, AND REPEAL

TO: All Concerned Persons

1. On May 14, 2009, the Department of Public Health and Human Services published MAR Notice No. 37-471 pertaining to the public hearing on the proposed adoption, amendment, and repeal of the above-stated rules at page 604 of the 2009 Montana Administrative Register, Issue Number 9. The department held a public hearing on June 3, 2009, and the initial comment period was scheduled to end on June 11, 2009.

2. On August 7, 2009, at 10:00 a.m., the Department of Public Health and Human Services will hold a second public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 North Sanders, Helena, Montana, to consider the proposed adoption, amendment, and repeal of the

above-stated rules. This second hearing will supplement the hearing held on June 3, 2009.

3. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you need to request an accommodation, contact the department no later than 5:00 p.m. on July 28, 2009 to advise us of the nature of the accommodation that you need. Please contact Gwen Knight, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406) 444-9503; FAX (406) 444-9744; e-mail dphhslegal@mt.gov.

4. The department is also extending the time within which to submit written comments. Written data, views, or arguments may be submitted to Gwen Knight at the contact information listed in paragraph 3, and must be received no later than 5:00 p.m. on August 13, 2009. Persons who testified at the initial hearing, or who submitted comments during the initial comment period, need not testify again or resubmit their comments. Any such previous testimony and comments will be included in the rulemaking record.

5. It has come to the attention of the department that a certain limited number of interested persons may not have been sent notice of the proposed adoption, amendment, and repeal when notice was initially published. Additionally, several persons requested additional time to review and comment on the proposed rules given the size of the proposed rule changes. The second hearing and extended comment period are intended to provide these persons with the opportunity to testify and submit written comments.

6. The rules proposed to be adopted, amended, and repealed remain the same as published in MAR Notice No. 37-471.

7. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct this hearing.

8. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 3 above or may be made by completing a request form at any rules hearing held by the department.

9. An electronic copy of this Proposal Notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the Notice conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all

concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

10. The bill sponsor contact requirements of 2-4-302, MCA, apply and have been fulfilled. The primary bill sponsor was contacted by letter dated February 14, 2008, sent postage prepaid via USPS.

/s/ Kimberly Kradolfer
Rule Reviewer

/s/ Anna Whiting Sorrell
Anna Whiting Sorrell, Director
Public Health and Human Services

Certified to the Secretary of State July 6, 2009.

BEFORE THE STATE AUDITOR AND COMMISSIONER OF INSURANCE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 6.6.504, 6.6.506, 6.6.507, 6.6.507A, 6.6.507B, 6.6.507C, 6.6.508, 6.6.508A, 6.6.509, and 6.6.511, and the adoption of New Rule I (ARM 6.6.507D), New Rule II (ARM 6.6.507E), New Rule III (ARM 6.6.527), and New Rule IV (ARM 6.6.511A), pertaining to Medicare Supplements	))))))))))	NOTICE OF AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On May 14, 2009, the State Auditor and Commissioner of Insurance published MAR Notice No. 6-184 regarding the public hearing on the proposed amendment and adoption of the above-stated rules at page 506 of the 2009 Montana Administrative Register, issue number 9.

2. On June 4, 2009, the State Auditor and Commissioner of Insurance held a public hearing to consider the proposed amendment and adoption of the above-stated rules.

3. The State Auditor and Commissioner of Insurance has amended ARM 6.6.506, 6.6.507C, 6.6.508, and 6.6.508A exactly as proposed, and has amended 6.6.504, 6.6.507, 6.6.507A, 6.6.507B, 6.6.509, and 6.6.511 as proposed, but with the following changes, stricken matter interlined, new matter underlined:

6.6.504 DEFINITIONS For purposes of this subchapter, the terms defined in 33-22-903, MCA, will have the same meaning in this subchapter unless clearly designated otherwise. The following definitions are in addition to those in 33-22-903, MCA.

(1) through (12) remain as proposed.

(13) "1990 standardized Medicare Supplement Benefit Plan," "1990 standardized benefit plan," or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 16, 1993, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

(14) "2010 standardized Medicare Supplement Benefit Plan," "2010 standardized benefit plan," or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

(15) remains as proposed.

6.6.507 ~~MINIMUM~~ BENEFIT STANDARDS FOR MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED OR DELIVERED WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010 (1) 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 prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(a) through (5)(c)(ii)(C) remain as proposed.

6.6.507A STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER ~~1990~~ JULY 1993, AND WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010

(1) through (7) remain as proposed.

6.6.507B OPEN ENROLLMENT (1) 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 a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for a policy or certificate is submitted prior to or during the six-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~~, or if open enrollment was delayed due to employment past age 65~~. Each Medicare supplement policy or certificate currently available from an issuer must be made available to all applicants who qualify under this rule without regard to age.

(2) through (4) remain as proposed.

6.6.509 REQUIRED DISCLOSURE PROVISIONS (1) through (9)(b) remain as proposed.

(c) The following items must be included in the outline of coverage in the order prescribed below:

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page: 1 of 2
Benefit Plan(s)____[insert letter(s) of plan(s) being offered]

These charts show the benefits included in each of the 1990 standardized Medicare supplement plans. Every company must make available Plan A. Some plans may not be available in your state. New 1990 standardized benefit plans may not be issued on or after June 1, 2010.

See Outline of Coverage sections for details about ALL plans

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), copayments for hospital outpatient services.
Blood: First three pints of blood each year.

A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care NOT covered by Medicare

F	F*	G	H	I	J	J*
Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	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	
Part B Deductible					Part B Deductible	
Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
		At-Home Recovery		At-Home Recovery	At-Home Recovery	
					Preventive Care NOT covered by Medicare	

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $2000~~1860~~ deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed $2000~~1860~~. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[COMPANY NAME]
Outline of Medicare Supplement Coverage - Cover Page 2

Basic Benefits for Plans K and L: include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**

Basic Benefits	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive services	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4620~~4140~~] Out of Pocket Annual Limit***	$[2310~~2070~~] Out of Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plan A - J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

Benefit Chart of Medicare Supplement Plans Sold with an effective date for coverage on or After June 1, 2010.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved 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
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
		Skilled Nursing Facility Coinsurance	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
		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

K	L	M	N
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
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	50% Part A Deductible	50% Part A Deductible	50% Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[4620~~4140~~]; paid at 100% after limit reached	Out-of-pocket limit $[2310~~2070~~]; paid at 100% after limit reached		

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2000~~1860~~] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2000~~1860~~]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

(10) and (11) remain as proposed.

6.6.511 SAMPLE FORMS OUTLINING COVERAGE (1) remains as proposed.

(a) inpatient hospital deductible = $1068~~992~~.00;

(b) daily coinsurance amount for the 61st through 90th days of hospitalization in a benefit period = $267~~248~~.00;

(c) daily coinsurance amount for lifetime reserve days = $534~~496~~.00;

(d) daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $133.50~~124.00~~;

(e) 50% of inpatient hospital deductible = $534~~496~~.00;

(f) 75% of inpatient hospital deductible = $801~~744~~.00;

(g) 25% of inpatient hospital deductible = $267~~248~~.00;

(h) 50% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $66.75~~62.00~~;

(i) 75% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $100.13~~93.00~~; and

(j) 25% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $33.38~~31.00~~.

(2) and (2)(a) remain as proposed.

(b) Plan A - Medicare (Part A) - Hospital Services - Per Benefit Period remains as proposed.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
--First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare ---approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
---Remainder of Medicare approved amounts	80%	20%	$0

(c) Plan B - Medicare (Part A) - Hospital Services - Per Benefit Period remains as proposed.

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 Next $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[135~~131~~] (Part B deductible) $0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $[135~~131~~] (Part B deductible) $0

(d) Plan C - Medicare (Part A) - Hospital Services - Per Benefit Period remains as proposed.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$[135~~131~~] (Part B deductible) Generally 20%	$0 $0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs

BLOOD First 3 pints	$0	All costs	$0
Next $[135~~131~~] of Medicare approved amounts*	$0	$[135~~131~~] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[135~~131~~] of Medicare approved amounts*	$0	$[135~~131~~] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

PLAN C

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

(e) Plan D - Medicare (Part A) - Hospital Services - Per Benefit Year remains as proposed.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[135~~131~~] (Part B deductible) $0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[135~~131~~] (Part B deductible) $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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
Remainder of Medicare approved amounts*	80%	20%	$0
AT-HOME RECOVERY SERVICES- NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
---Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(f) Plan E - Medicare (Part A) - Hospital Services - Per Benefit Period remains as proposed.

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER BENEFIT PERIOD

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE, Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICARE CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

(g) 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 $[2000~~1860~~] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[2000~~1860~~]. 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 $[2000~~1860~~] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATON* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but [6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% 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 $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] 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 $[2000~~1860~~] deductible. Benefits from the high deductible Plan F will begin until out-of-pocket expenses are $[2000~~1860~~]. 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 $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] 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 $[135~~131~~] of Medicare approved amounts*	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$[135~~131~~] (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 $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] DEDUCTIBLE,**] YOU PAY

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[135~~131~~] of Medicare approved amounts*	$0	$[135~~131~~] (Part B deductible)	$0
---Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] 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

(h) Plan G - Medicare (Part A) - Hospital Services - Per Benefit Period remains as proposed.

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[135~~131~~] (Part B deductible) $0
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD First 3 pints Next $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[135~~131~~] (Part B deductible) $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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan ---Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
---Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(i) Plan H - Medicare (Part A) - Hospital Services - Per Benefit Period remains as proposed.

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[135~~131~~] (Part B deductible) $0
Part B Excess Charges (Above Medicare approved amounts)	$0	0%	All costs
BLOOD First 3 pints Next $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[135~~131~~] (Part B deductible) $0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN H

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $[135~~131~~] (Part B deductible) $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

(j) Plan I - Medicare (Part A) - Hospital Services - Per Benefit Period remains as proposed.

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN I

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan ---Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
---Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(k) PLAN J or HIGH DEDUCTIBLE PLAN J

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year $[2000~~1860~~] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[2000~~1860~~]. 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 $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO [$2000~~1860~~] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] 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 $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] 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 as plan J after one has paid a calendar year $[2000~~1860~~] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[2000~~1860~~]. 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 $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] 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 $[135~~131~~] of Medicare approved amounts*	$0	$[135~~131~~] (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		$0
Next $[135~~131~~] of Medicare approved amounts*	$0	All costs $[135~~131~~] (Part B deductible)	$0
Remainder of Medicare approved amounts	$0	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[135~~131~~] of Medicare approved amounts*	$0	$[135~~131~~] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
HOME HEALTH CARE AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual charges to $40 a visit	Balance
Number of visits covered (Must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

PLAN J or HIGH DEDUCTIBLE PLAN J
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] 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

***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

(l) PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4620~~4140~~] 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		$[6.6.511(1)(a)]	$[6.6.511(1)(e)]♦
First 60 days	All but $[6.6.511(1)(a)]	(50% of Part A deductible)	(50% of Part A deductible)
61st thru 90th day	All but [6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] 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 $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(h)] a day	Up to $[6.6.511(1)(h)]♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 50% $0	 50%♦ $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 [$4620~~4140~~])*
BLOOD First 3 pints	$0	50%	50%♦
Next $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[4620~~4140~~] 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 $[135~~131~~] of Medicare approved amounts*****	$0	$0	$[135~~131~~] (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

(m) PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2310~~2070~~] each calendar year. The amounts that count toward your annual limit are noted with a diamond (♦) 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		$[6.6.511(1)(f)]	$[6.6.511(1)(g)]
First 60 days	All but $[6.6.511(1)(a)]	(75% of Part A deductible)	25% of Part A deductible♦
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] 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 $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(i)] a day	Up to $[6.6.511](1)(j)] a day♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	$0 100%	75% $0	25%♦ $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135~~131~~] of Medicare approved amounts****	$0	$0	$[135~~131~~] (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 [$2310~~2070~~])*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[135~~131~~] of Medicare approved amounts****	$0	$0	$[135~~131~~] (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 $[2310~~2070~~] 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 $[135~~131~~] of Medicare approved amounts*****	$0	$0	$[135~~131~~] (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.

4. The State Auditor and Commissioner of Insurance has adopted New Rule III (ARM 6.6.527) exactly as proposed, and has adopted New Rule I (ARM 6.6.507D), New Rule II (ARM 6.6.507E), and New Rule IV (ARM 6.6.511A), exactly as proposed, but with the following changes, stricken matter interlined, new matter underlined:

NEW RULE I (ARM 6.6.507D) 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 (1) 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 advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate with an effective date for coverage on or after June 1, 2010, unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare Supplement Benefit Plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010, remain subject to the requirements of ARM 6.6.507 and other applicable rules and statutes contained in this subchapter and Title 33, chapter 22, part 9, MCA.

(a) through (3) remain as proposed.

(a) if such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate must be automatically reinstituted effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of the termination of entitlement;

(b) through (4)(b)(vi) remain as proposed.

NEW RULE II (ARM 6.6.507E) STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED WITH AN EFFECTIVE DATE FOR COVERAGE ~~FOR DELIVERY~~ ON OR AFTER JUNE 1, 2010 (1) 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 advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates ~~issued~~ with an effective date for coverage before June 1, 2010, remain subject to the requirements of ARM 6.6.507A.

(2) through (7)(b) remain as proposed.

(i) the core benefit as established in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible as established in ARM 6.6.507D(4)(b).

(c) and (c)(i) remain as proposed.

(ii) 100% of the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b).

(d) and (d)(i) remain as proposed.

(ii) 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as established in ARM 6.6.507D(4)(b).

(e) standardized Medicare Supplement Benefit regular Plan F must include only the following:

(i) remains as proposed.

(ii) 100% of the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b).

(f) through (7)(f)(i)(A) remain as proposed.

(B) 100% of the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in ARM 6.6.507D(4)(b);

(ii) The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement regular Plan F policy, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1500 and shall be adjusted annually from 1999 by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(g) and (7)(g)(i) remain as proposed.

(ii) 100% of the Medicare Part A deductible, the skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b).

(8) The following descriptions detail the contents of two Medicare supplement plans ~~mandated~~ authorized by the MMA:

(a) through (11) remain as proposed.

NEW RULE IV (ARM 6.6.511A) SAMPLE FORMS OUTLINING COVERAGE (1) The following amounts, as published in the Federal Register, for services furnished in the current calendar year under Medicare's hospital insurance program (Medicare Part A), must apply to the charts for Plans A, B, C, D, F, and High Deductible Plan F, G, K~~.~~, L, M, and N, issued on or after June 1, 2010, in (2)(b) through (m). In each chart, the rule cited in brackets as ARM [6.6.511A(1)(a)], [6.6.511A(1)(b)], [6.6.511A(1)(c)], [6.6.511A(1)(d)], [6.6.511A(1)(e)], [6.6.511A(1)(f)], [6.6.511A(1)(g)], [6.6.511A(1)(h)], [6.6.511A(1)(i)], or [6.6.511A(1)(j)], represents the dollar amount specified in the cited rule subsection. The issuer must replace each bracket and rule cite with the correct dollar amount contained in the cited rule subsection when the issuer prints the charts:

(a) inpatient hospital deductible = $~~992~~1068.00;

(b) daily coinsurance amount for the 61st through 90th days of hospitalization in a benefit period = $~~248~~267.00;

(c) daily coinsurance amount for lifetime reserve days = $~~496~~534.00;

(d) daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $~~124.00~~133.50;

(e) 50% of inpatient hospital deductible = $~~496~~534.00;

(f) 75% of inpatient hospital deductible = $~~744~~801.00;

(g) 25% of inpatient hospital deductible = $~~248~~267.00;

(h) 50% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $~~62.00~~66.75;

(i) 75% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $~~93.00~~100.13; and

(j) 25% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $~~31.00~~33.38.

(2) through (a) remain as proposed.

(b) 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 $[6.6.511A(1)(a)]	$0	$[6.6.511A(1)(a)] (Part A deductible)
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible	
---Additional 365 days	$0	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 $[6.6.511A(1)(d)] a day	$0	Up to $[6.6.511A(1)(d)] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, --First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare ---approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
---Remainder of Medicare approved amounts	80%	20%	$0

(c) 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 $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: ---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] 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 $[6.6.511A(1)(d)] a day	$0	Up to $[6.6.511A(1)(d)] 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

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$[135~~131~~] (Part B deductible) $0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[135~~131~~] (Part B deductible) $0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $0 20%	$0 $[135~~131~~] (Part B deductible) $0

(d) 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 $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] 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 $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$[135~~131~~] (Part B deductible) Generally 20%	$0 $0
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $[135~~131~~] (Part B deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	100% $0 80%	$0 $[135~~131~~] (Part B deductible) 20%	$0 $0 $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 Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

(e) PLAN D

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

*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 $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511A(1)(a)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] 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 $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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

(f) 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 $[2000~~1860~~] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[2000~~1860~~]. 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 $[2000~~1860~~] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATON* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but [6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% 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 $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare coinsurance/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] 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 $[2000~~1860~~] deductible. Benefits from the high deductible Plan F will begin until out-of-pocket expenses are $[2000~~1860~~]. 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 $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] 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 $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$[135~~131~~] (Part B deductible) Generally 20%	$0 $0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD First 3 pints Next $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $[135~~131~~] (Part B deductible) 20%	$0 $0 $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 $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies ---Durable medical equipment First $[135~~131~~] of Medicare approved amounts* ---Remainder of Medicare approved amounts	100% $0 80%	$0 $135[~~131~~] (Part B deductible) 20%	$0 $0 $0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000~~1860~~] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000~~1860~~] 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

(g) 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 $[6.6.511A(1)(a)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: ---While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] a day	$0
---Once lifetime reserve days are used: ---Additional 365 days	$0	100% 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 $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(d)] 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 insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $[135~~131~~] (Part B deductible) $0
Part B Excess Charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD First 3 pints Next $[135~~131~~] of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $[135~~131~~] (Part B deductible) $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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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

(h) PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4620~~4140~~] 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		$[6.6.511A(1)(a)]	
First 60 days	All but $[6.6.511A(1)(a)]	(50% of Part A deductible)	$[6.6.511A(1)(e)]♦
61st thru 90th day	All but [6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] 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 $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(h)] a day	Up to $[6.6.511A(1)(h)]♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 50% $0	 50%♦ $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 [$4620~~4140~~])*
BLOOD First 3 pints	$0	50%	50%♦
Next $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[4620~~4140~~] 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 $[135~~131~~] of Medicare approved amounts*****	$0	$0	$[135~~131~~] (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

(i) PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2310~~2070~~] each calendar year. The amounts that count toward your annual limit are noted with a diamond (♦) 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 $[6.6.511A(1)(a)]	$[6.6.511A(1)(f)] (75% of Part A deductible)	$[6.6.511A(1)(g)] 25% of Part A deductible♦
61st thru 90th day	All but $[6.6.511A(1)(b)] a day	$[6.6.511A(1)(b)] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)] a day	$[6.6.511A(1)(c)] 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 $[6.6.511A(1)(d)] a day	Up to $[6.6.511A(1)(i)] a day	Up to $[6.6.511A](1)(j)] 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	25% of copayment/ coinsurance♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135~~131~~] of Medicare approved amounts****	$0	$0	$[135~~131~~] (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 [$2310~~2070~~])*
BLOOD First 3 pints	$0	75%	25%♦
Next $[135~~131~~] of Medicare approved amounts****	$0	$0	$[135~~131~~] (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 $[2310~~2070~~] 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 $[135~~131~~] of Medicare approved amounts*****	$0	$0	$[135~~131~~] (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.

(j) PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $[6.6.511A(1)(a) ~~992~~]	$[6.6.511A(1)(e) ~~496~~](50% of Part A deductible)	$[6.6.511A(1)(e) ~~496~~](50% of Part A deductible)
61st through 90th day	All but $[6.6.511A(1)(b)~~248~~] a day	$[6.6.511A(1)(b) ~~248~~] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)~~496~~] a day	$[6.6.511A(1)(c) ~~496~~] 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 through 100th day	All but $[6.6.511A(1)(d)~~124~~] a day	Up to $[6.6.511A(1)(d) ~~124~~] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drug and inpatient respite care	Medicare copayment/ Coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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

(k) 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 $[6.6.511A(1)(a)~~992~~]	$[6.6.511A(1)(a)~~992~~] (Part A deductible)	$0
61st through 90th day	All but $[6.6.511A(1)(b)~~248~~] a day	$[6.6.511A(1)(b)~~248~~] a day	$0
91st day and after: While using 60 lifetime reserve days	All but $[6.6.511A(1)(c)~~496~~] a day	$[6.6.511A(1)(c)~~496~~] 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 through 100th day	All but $[6.6.511A(1)(d)~~124~~] a day	Up to $[6.6.511A(1)(d)~~124~~] 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 drug and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $[135~~131~~] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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

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 $[135~~131~~] of Medicare approved amounts*	$0	$0	$[135~~131~~] (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

4. No comments were heard at the hearing, however the following written comments were received and appear with the State Auditor's responses:

COMMENT NO. 1: One commenter stated that an effective date was not included for these rules and suggests that the effective date be the date upon which the rules are adopted.

RESPONSE NO. 1: A stated effective date is not necessary because these rules will automatically be effective the day after publication, unless otherwise specifically stated. In this case, these rules will be effective July 17, 2009, except New Rule III (ARM 6.6.527), relating to genetic nondiscrimination, which will be applied retroactively beginning July 1, 2009.

COMMENT NO. 2: One commenter requested that the department add the phrase "with an effective date for coverage" throughout the proposed rules when referencing the 1990 and 2010 Medicare supplement policies or certificates, so that carriers are not precluded from issuing or delivering the new policies before June 2010. This will ensure that consumers do not experience a break in coverage. The commenter states that this approach is consistent with the NAIC model regulation.

RESPONSE NO. 2: The department will make the suggested changes. However, it is noted that this language is not part of the NAIC model regulation, but rather appeared as "Optional Technical Clarifications" issued in a separate bulletin on April 1, 2009.

COMMENT NO. 3: One commenter states that the benefit standards for Medicare supplement policies or certificates contained in 6.6.507 apply to all pre-June 2010 policies, instead of having separate benefit standards sections for policies issued pre-1993, and policies issued between 1993 and June 2010. The NAIC model regulation is written with two separate sections for each of those time periods.

RESPONSE NO. 3: Although the NAIC model is written in with two separate sections for those time periods, the Montana rules did not adopt that approach in the past, and the department declines to make that change at this time. The Montana rule as written is at least as protective as the requirements of the Federal regulations. The department has not had any complaints or problems with the administration of this rule, even though it has never adopted separate rules for policies issued pre-1993.

COMMENT NO. 4: Two commenters state that the amendment to 6.6.507B that seeks to clarify the open enrollment rights for individuals working past age 65 "who voluntarily terminate enrollment in a group health plan" go beyond the language provided in the NAIC model regulation because the amendment adds the language: "or if open enrollment was delayed due to employment past age 65." The commenters suggest that this language is unnecessary, and will cause confusion because open enrollment is not triggered until a person turns 65, or older, and first enrolls in Part B.

RESPONSE NO. 4: Because of the possibility of confusion or ambiguity, the department will remove the language "or if open enrollment was delayed due to employment past age 65." The department considered adding this language because it has come to our attention that producers and insurers sometimes advise consumers to enroll in Part B, even when they are actively at work and enrolled as employee members of a group health plan.

COMMENT NO. 5: Both commenters make numerous suggestions regarding editing, typographical errors, or technical corrections.

RESPONSE NO. 5: Most of those suggested changes have been made. The following suggested changes have not been made:

a. A suggestion was made to bold and underline text in the introductory language for the (Medicare Part A) benefit charts to bring attention to the disclaimer. The Secretary of State's policy is that all text is printed in Arial 12 font, with no bold or italics unless a Latin name is used. Underlining indicates "new text," in a rule, and will not be used.

b. It was suggested that the Benefit Charts for Plans K through N be modified to incorporate additional rows shaded in gray so the appropriate rows for Medicare Part B and Medicare Part B excess coverage are included in the chart with the appropriate payment levels, and for proper alignment with the Summary Benefit

information for Plans A, B, C, D, E, F, and G. The department inserted two rows for alignment; however, shading will not be used because it does not photocopy well into the Register or ARM print copy.

COMMENT NO. 6: One commenter stated that the following language in New Rule II (ARM 6.6.507E)(8) ("Plans K and L are mandated by the MMA") should be changed from "mandated" to "authorized."

RESPONSE NO. 6: The department has made that change.

COMMENT NO. 7: One commenter states that the Medicare A and B deductibles and co-insurance rates are less than the current 2009 rates published by the Center for Medicare Medicaid Services.

RESPONSE NO. 7: The department agrees and has made those changes.

5. The State Auditor's Office intends to apply ARM 6.6.527 retroactively back to July 1, 2009.

/s/ Christina L. Goe
Christina L. Goe
Rule Reviewer

/s/ Robert W. Moon
Robert W. Moon
Deputy State Auditor

Certified to the Secretary of State July 6, 2009.

BEFORE THE FISH, WILDLIFE AND PARKS COMMISSION
OF THE STATE OF MONTANA

In the matter of the repeal of a temporary emergency rule closing the Belt Creek within Sluice Boxes State Park from Logging Creek Bridge to Riceville Bridge in Cascade County	)))))	NOTICE OF REPEAL OF A TEMPORARY EMERGENCY RULE

TO: All Concerned Persons

1. On May 27, 2009, the Fish, Wildlife and Parks Commission (commission) adopted a temporary emergency rule closing the Belt Creek within Sluice Boxes State Park, published at page 939 of the 2009 Montana Administrative Register, Issue No. 11. There was a log jam that created an obstruction in a narrow, steep-walled section of a canyon that caused the river to be impassable by recreationists. This situation constituted an imminent peril to the public health, safety, and welfare of anyone recreating on the river.

2. The log jam has been removed and the temporary emergency rule closing the Belt Creek within Sluice Boxes State Park, MAR Notice No. 12-355, is no longer necessary. As this situation no longer constitutes an imminent peril to public health, safety, and welfare, the commission is repealing the rule. The repeal of the rule will be sent as a press release to newspapers throughout the state. Also, signs informing the public of the closure will be removed at access points. The repeal notice will be sent to interested parties, and published in Issue No. 13 of the 2009 Montana Administrative Register.

3. The repeal of the temporary emergency rule is effective June 23, 2009.

4. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

/s/ Joe Maurier
Joe Maurier, Secretary
Fish, Wildlife and Parks Commission

/s/ Bill Schenk
Bill Schenk
Rule Reviewer

Certified to the Secretary of State June 23, 2009.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 23.19.1001, concerning consumer debt management license fee	)))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On May 28, 2009, the Department of Justice published MAR Notice No. 23-19-211, pertaining to the proposed amendment of the above-stated rule at page 810 of the 2009 Montana Administrative Register, Issue Number 10.

2. The department has amended the above-stated rule as proposed.

3. The department has thoroughly considered the comments and testimony received. A summary of the comments received and the department's responses are as follows:

COMMENT 1: The American Association of Debt Management Organizations fully supports the reduction of the license fee.

RESPONSE 1: The department appreciates the comment and support.

By: /s/ Steve Bullock
STEVE BULLOCK
Attorney General
Department of Justice

/s/ J. Stuart Segrest
J. STUART SEGREST
Rule Reviewer

Certified to the Secretary of State July 6, 2009.

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the adoption of NEW RULE I pertaining to licensee lookup database	)))	NOTICE OF ADOPTION

TO: All Concerned Persons

1. On January 29, 2009, the Department of Labor and Industry (department) published MAR Notice No. 24-101-203 regarding the public hearing on the proposed adoption of the above-stated rule, at page 61 of the 2009 Montana Administrative Register, issue no. 2.

2. On February 19, 2009, a public hearing was held on the proposed adoption of the above-stated rule in Helena. Several comments were received by the February 27, 2009, deadline.

3. The department has thoroughly considered the comments and testimony received. A summary of the comments received and the department's responses are as follows:

COMMENT 1: Two commenters questioned how long a licensee's discipline will be posted on the licensee lookup system.

RESPONSE 1: Senate Bill 453, as implemented through New Rule I, did not provide for any time limitation on the posting of final disciplinary actions against licensees. Therefore, the public posting of final discipline will be perpetual.

COMMENT 2: One commenter stated that posting all discipline forever is unfair. The commenter suggested the department limit indefinite posting for health and safety infractions, and post other discipline only until a licensee makes the necessary corrections.

RESPONSE 2: Senate Bill 453, as implemented through New Rule I, did not differentiate between types of violations or levels of severity in disciplinary actions to be included in licensee lookup. Therefore, all disciplinary actions will be publicly posted pursuant to the statutory requirements of 37-1-311 and 37-1-405, MCA.

COMMENT 3: One commenter opposed the new rule and stated that it duplicates what is currently in place. The commenter stated that posting discipline creates a hardship to those wrongly accused and allows people doing internet searches to find a "conviction without due process."

RESPONSE 3: Senate Bill 453 required the department to report certain final disciplinary actions to the public and do so via a publicly available web site. New Rule I further implements the legislation to accomplish the statutory intent. No final

orders will be placed on licensee lookup prior to completion of administrative due process.

COMMENT 4: One commenter suggested amending the new rule to require that the beginning and end dates of a licensee's discipline are included on licensee lookup.

RESPONSE 4: The updated licensee lookup system will provide a link between the licensee and the actual final disciplinary documents issued in a specific case. Individuals will be able to read the final documents themselves to determine dates of licensee discipline.

COMMENT 5: A commenter questioned how the discipline posting would work when a licensee holds more than one license.

RESPONSE 5: The updated licensee lookup system will link final disciplinary documents to the appropriate license or licenses.

COMMENT 6: A commenter asked how posting would be accomplished if a board decision went to a department contested case hearing or was appealed to district court.

RESPONSE 6: The final disciplinary documents will not be posted on licensee lookup until the board or departmental program has issued a final order in a particular case regardless of whether the licensee seeks judicial review. If a case is later reversed on appeal, the department would then remove the discipline and the related documents from licensee lookup.

COMMENT 7: One commenter asked that her discipline be removed from licensee lookup.

RESPONSE 7: Disciplinary actions are reported and maintained indefinitely; therefore, the department is unable to grant the commenter's request.

COMMENT 8: A commenter suggested omitting from licensee lookup those licensees with single nonsevere offenses who complied with all disciplinary requirements and didn't reoffend. The commenter recommended licensee lookup only for those with severe offenses or those who reoffend.

RESPONSE 8: Senate Bill 453, as implemented through New Rule I, did not differentiate between types or number of violations or levels of severity in disciplinary actions to be included in licensee lookup. Therefore, all disciplinary actions will be publicly posted pursuant to the statutory requirements of 37-1-311 and 37-1-405, MCA.

COMMENT 9: A few commenters stated that the current language on licensee lookup is misleading and requested that the department provide complete information on the nature and timing of the discipline.

RESPONSE 9: The updated licensee lookup system will provide a link between the licensee and the actual final disciplinary documents issued in a specific case. Individuals will be able to read the final documents themselves to determine the nature and timing of licensee discipline. The department anticipates that the language in question will be modified or eliminated.

COMMENT 10: One commenter suggested amending the new rule to reference the definition of "disciplinary action" in ARM 24.101.402, or placing the new rule close to the definitions rule.

RESPONSE 10: The department intends to locate New Rule I in the same vicinity as ARM 24.101.402, the definitions rule.

COMMENT 11: A commenter suggested amending New Rule I to clarify what is meant in 37-1-311 and 37-1-405, MCA, by posting discipline within "a reasonable amount of time." The commenter also suggested adding a deadline for when such discipline has to be posted online.

RESPONSE 11: The fact that a licensee has an action pending before a board will be noted on the licensee lookup and the public can contact the applicable board or program for additional information. Final disciplinary documents will not be posted on licensee lookup until the board or program has issued a final order in a particular case. Because there is no way to predict when each case will be resolved and a final order issued, it is not feasible to set a deadline for posting updated information.

4. The department has adopted NEW RULE I (24.101.404) exactly as proposed.

/s/ DARCEE L. MOE
Darcee L. Moe
Alternate Rule Reviewer

/s/ KEITH KELLY
Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State July 6, 2009

NOTICE OF FUNCTION OF ADMINISTRATIVE RULE REVIEW COMMITTEE

Interim Committees and the Environmental Quality Council

Administrative rule review is a function of interim committees and the Environmental Quality Council (EQC). These interim committees and the EQC have administrative rule review, program evaluation, and monitoring functions for the following executive branch agencies and the entities attached to agencies for administrative purposes.

Economic Affairs Interim Committee:

- Department of Agriculture;
- Department of Commerce;
- Department of Labor and Industry;
- Department of Livestock;
- Office of the State Auditor and Insurance Commissioner; and
- Office of Economic Development.

Education and Local Government Interim Committee:

- State Board of Education;
- Board of Public Education;
- Board of Regents of Higher Education; and
- Office of Public Instruction.

Children, Families, Health, and Human Services Interim Committee:

- Department of Public Health and Human Services.

Law and Justice Interim Committee:

- Department of Corrections; and
- Department of Justice.

Energy and Telecommunications Interim Committee:

- Department of Public Service Regulation.

Revenue and Transportation Interim Committee:

- Department of Revenue; and
- Department of Transportation.

State Administration and Veterans' Affairs Interim Committee:

- Department of Administration;
- Department of Military Affairs; and
- Office of the Secretary of State.

Environmental Quality Council:

- Department of Environmental Quality;
- Department of Fish, Wildlife, and Parks; and
- Department of Natural Resources and Conservation.

These interim committees and the EQC have the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. They also may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a bill repealing a rule, or directing an agency to adopt or amend a rule, or a Joint Resolution recommending that an agency adopt, amend, or repeal a rule.

The interim committees and the EQC welcome comments and invite members of the public to appear before them or to send written statements in order to bring to their attention any difficulties with the existing or proposed rules. The mailing address is P.O. Box 201706, Helena, MT 59620-1706.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definitions:

Administrative Rules of Montana (ARM) is a looseleaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR or Register) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statutes and rules by the Attorney General (Attorney General's Opinions) and agencies (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject

1. Consult ARM Topical Index.
   Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.

Statute

2. Go to cross reference table at end of each number and title which lists MCA section numbers and department corresponding ARM rule numbers.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies that have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 2009. This table includes those rules adopted during the period April 1, 2009, through June 30, 2009, and any proposed rule action that was pending during the past six-month period. (A notice of adoption must be published within six months of the published notice of the proposed rule.) This table does not include the contents of this issue of the Montana Administrative Register (MAR or Register).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 2009, this table, and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule, and the page number at which the action is published in the 2008 and 2009 Montana Administrative Register.

To aid the user, the Accumulative Table includes rulemaking actions of such entities as boards and commissions listed separately under their appropriate title number.

GENERAL PROVISIONS, Title 1

1.3.201 and other rule - Definitions - MAPA, p. 2418, 7

ADMINISTRATION, Department of, Title 2

I Waiver of In-State Office Requirement, p. 2320, 2621
2.5.502 and other rule - Contract Security, p. 2310, 2616
2.59.401 Credit Union Supervisory and Examination Fees, p. 2323, 2620
2.59.1711 Continuing Education, p. 159, 735

(Public Employees' Retirement Board)
2.43.203 and other rules - Operation of the Retirement Systems and Plans Administered by the Montana Public Employees' Retirement Board, p. 1852, 2467, 78
2.43.1001 Adoption by Reference of the State of Montana Public Employee Defined Contribution Plan Document, January 1, 2008, Edition, p. 2396, 82
2.43.1801 Adoption by Reference of the State of Montana Public Employee Deferred Compensation Plan Document, January 1, 2008, Edition, p. 2393, 81
2.43.3502 and other rule - (Public Employees' Retirement Board) Investment Policy Statement for the Defined Contribution Retirement Plan - Investment Policy Statement for the 457 Deferred Compensation Plan, p. 394, 1010

(Teachers' Retirement Board)

2.44.301A and other rules - Administration of the Teachers' Retirement System of the State of Montana, p. 2313, 2619, 3

(State Compensation Insurance Fund)

2.55.320 and other rule - Classifications of Employments - Construction Industry Premium Credit Program, p. 2399, 140

AGRICULTURE, Department of, Title 4

4.9.401 Raising the Wheat and Barley Assessment, p. 2574, 264

4.10.401 Farm Applicator Licensing Schedule, p. 2198, 2557

4.12.1320 and other rules - Quarantines - Pest Management Standards, p. 118, 343

STATE AUDITOR, Title 6

6.6.504 and other rules - Medicare Supplements, p. 506

6.6.2101 and other rules - Discrimination, p. 2403, 83

6.6.3504 and other rules - Annual Audited Reports - Establishing Accounting Practices and Procedures to be Used in Annual Statements - Actuarial Opinion - Annual Audit - Required Opinions - Statement of Actuarial Opinion Not Including an Asset Adequacy Analysis - Additional Considerations for Analysis, p. 2201, 2622

COMMERCE, Department of, Title 8

I Administration of the 2009-2010 Federal Community Development Block Grant (CDBG) Program, p. 2408, 410

8.99.901 and other rules - Award of Grants and Loans Under the Big Sky Economic Development Program, p. 2411, 141

8.119.101 Tourism Advisory Council, p. 398, 862

(Montana Coal Board)

8.101.201 and other rules - Policies of the Montana Coal Board - Applications for Montana Coal Board Grant Assistance, p. 2220, 344

(Board of Housing)

8.111.602 Low Income Housing Tax Credit Program, p. 952

EDUCATION, Department of, Title 10

(Board of Public Education)

10.54.4010 and other rules - Math Content Standards and Performance Descriptors, p. 767

10.57.102 and other rules - Educator Licensure, p. 30, 345

23.12.1201 and other rules - Attendance at MLEA - Performance Criteria at MLEA, p. 401, 867

(Gambling Control Division)
23.16.202 and other rules - Gambling Business License - Approval of Variations of Standard Bingo Cards - Credit Play - Card Dealer Licenses - Card Room Contractors License Requirements - Sports Tab Game Seller License - Distributor Licenses - Route Operator Licenses - Manufacturer Licenses - Accounting System Vendor Licenses - Manufacturer of Illegal Gambling Devices License - Raffle Record Keeping Requirements, p. 912
23.16.1802 and other rules - Audit Data Storage Devices - Definitions - Record Keeping Requirements, p. 2540, 84, 143

LABOR AND INDUSTRY, Department of, Title 24

Boards under the Business Standards Division are listed in alphabetical order following the department rules.

I Licensee Lookup Database, p. 61
24.17.127 Prevailing Wage Rates for Public Works Projects - Building Construction Services, Heavy Construction Services, Highway Construction Services, and Nonconstruction Services, p. 249, 736, 868

24.29.1533 and other rule - Workers' Compensation Medical Fee Schedule for Nonfacilities, p. 2326, 8

(Human Rights Commission)
24.8.101 and other rules - Allegations of Unlawful Discrimination, p. 2091, 2636

(Alternative Health Care Board)
24.111.2102 and other rule - Continuing Education, p. 2577, 265

(Board of Architects and Landscape Architects)
24.114.101 and other rules - Board Organization - Procedural Rules - Definitions - Fees - Architect Seal - Architect Business Entity Practice - Emergency Use - Licensure By Examination - Unprofessional Conduct - Screening Panel - Architect Partnerships - Landscape Architect Licensure, p. 2545, 413

(Board of Chiropractors)
24.126.301 and other rules - Definitions - Applications - Display of License - Continuing Education - Unprofessional Conduct, p. 923

(State Electrical Board)
24.141.301 and other rules - Definitions - Fees - Applications - Temporary Practice Permits - Examinations - Continuing Education - Master Electrician Qualifications, p. 64

(Board of Medical Examiners)
I Medical Direction, p. 2238, 416
24.156.2719 Expired License, p. 2235, 415

(Board of Nursing)
24.159.301 and other rules - Definitions - Foreign Educated Applicants for RN Licensure Requirements - APRNs, p. 875, 2346, 2641
24.159.1006 and other rules - Cosmetic Procedure Standards - Nonroutine Applications, p. 252

(Board of Outfitters)
24.171.401 and other rules - Fees - Qualifications, p. 256

(Board of Physical Therapy Examiners)
24.177.405 and other rules - Physical Therapy Aides - Temporary Licenses - Out of State Applicants - Foreign Trained Applicants - Topical Medication Protocols - Continuing Education - Physical Therapists, p. 586

(Board of Private Alternative Adolescent Residential or Outdoor Programs)
24.181.301 and other rules - Definitions - Fees - Private Alternative Adolescent Residential and Outdoor Programs, p. 303
24.181.401 and other rules - Registration Fee Schedule - Licensing Fee Schedule - Renewals - Private Alternative Adolescent Residential and Outdoor Programs, p. 339, 870

(Board of Public Accountants)
24.201.301 and other rules - Accounting, p. 1654, 9

(Board of Realty Regulation)
24.210.301 and other rules - Definitions - Licensure - Unprofessional Conduct - Supervising Broker Endorsement - Citations and Fines, p. 1679, 2558
24.210.301 and other rules - Definitions - Licensing - Renewals - Unprofessional Conduct - Continuing Education, p. 928
24.210.641 Unprofessional Conduct, p. 2580, 748

(Board of Sanitarians)
24.216.402 and other rule - Fees - Sanitarian in Training, p. 75, 455

(Board of Social Work Examiners and Professional Counselors)
24.219.301 and other rules - Definitions - Fees - Application - Licensure - Status Conversion - Application - Continuing Education - Unprofessional

Conduct - Social Work Examiners and Professional Counselors, p. 2583, 812

LIVESTOCK, Department of, Title 32

32.23.301 Fees Charged by the Department on the Volume on All Classes of Milk, p. 2596, 144

NATURAL RESOURCES AND CONSERVATION, Department of, Title 36

36.10.132 and other rules - Firewarden Qualifications, Duties, and Legal Representation for State Firefighters, p. 2246, 2559
36.12.190 and other rule - Filing a Change Application - Change Application - Historic Use, p. 814

(Board of Land Commissioners)
I-XVIII (Board and Department) Selection, Implementation, and Reporting of Real Estate Projects on State Trust Lands, p. 1955, 2645

PUBLIC HEALTH AND HUMAN SERVICES, Department of, Title 37

I-VI Medical Marijuana Program, p. 2027, 322
I-IX Mental Health Center Services for Youth With Serious Emotional Disturbance (SED), p. 2603, 272
I-XXVII Behavioral Health Inpatient Facilities (BHIF), p. 844
37.5.117 and other rules - Establishing Hearings for Disputes Related to the Medicaid Drug Rebate Program, p. 2338, 2669
37.5.117 and other rules - Swimming Pools, Spas, and Other Water Features, p. 604
37.8.126 Grandparents and Relative Caregivers Access to Birth Records, p. 1007
37.8.1801 and other rules - Montana Central Tumor Registry, p. 2428, 87
37.10.101 and other rules - Living Wills, p. 1686, 2356, 86
37.30.405 Vocational Rehabilitation Program Payment for Services, p. 407, 941
37.40.307 and other rule - Medicaid Nursing Facility Reimbursement, p. 997
37.52.210 Adjustment of Subsidy Payment, p. 132, 417
37.75.101 and other rules - Child and Adult Care Food Program (CACFP), p. 2446, 88
37.78.102 and other rules - Temporary Assistance for Needy Families (TANF), p. 596,1020
37.81.304 Pharmacy Access Prescription Drug Benefit Program (Big Sky Rx), p. 2330, 2670
37.85.212 and other rule, Resource Based Relative Value Scale (RBRVS) Medicaid Provider Rates and Mid-Level Practitioner's Reimbursement for Services to Medicaid Clients Under Age 21, p. 436, 1012
37.85.903 and other rule - General Medicaid Services - Physician-Administered Drugs, p. 2129, 2671