ISSUE NO. 14

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 The Proposal Notice Section contains state agencies' proposed new, amended, or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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.

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PROPOSAL NOTICE SECTION

BEFORE THE COMMISSIONER OF SECURITIES AND INSURANCE
MONTANA STATE AUDITOR

In the matter of the amendment of ARM 6.6.507B, 6.6.507C, 6.6.507D, 6.6.507E, 6.6.509, 6.6.511, and 6.6.511A pertaining to Medicare Supplements	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On August 19, 2013, at 10:30 a.m., the Commissioner of Securities and Insurance, Montana State Auditor, will hold a public hearing in the 2nd floor conference room, at the Office of the Commissioner of Securities and Insurance, Montana State Auditor (CSI), 840 Helena Ave., Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The CSI 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 CSI no later than 5:00 p.m., August 12, 2013, to advise us of the nature of the accommodation that you need. Please contact Darla Sautter, CSI, 840 Helena Avenue, Helena, Montana, 59601; telephone (406) 444-2726; TDD (406) 444-3246; fax (406) 444-3499; or e-mail dsautter@mt.gov.

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

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:

(a) 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

(b) during the 63-day period following termination of coverage under a group or individual health insurance policy or certificate for a person enrolled, or eligible for enrollment in Medicare Part B, and who resides in this state, upon the request of the individual.

(2) 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)~~(a) If an applicant qualifies under ARM 6.6.507B(1)(a) or (b), ~~and~~ submits an application during ~~the~~ either time period referenced in (1) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition~~.~~; and

~~(3)~~(b) If the applicant qualifies under ARM 6.6.507B(1)(a) or (b), and submits an application during ~~the~~ either time period referenced in (1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this rule.

~~(4)~~(3) This rule must not be construed as preventing the exclusion of benefits under a policy, except as provided in (2)(a) and ~~(3)~~(2)(b), ARM 6.6.507C, and 6.6.522 during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before it became effective.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA
IMP: 33-22-902, 33-22-904, MCA

6.6.507C GUARANTEED ISSUE FOR ELIGIBLE PERSONS (1) through (2)(f) remain the same.

(g) the individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in (5)(e)~~.~~;

(h) the individual, upon first becoming eligible for benefits under Medicare Part A and B enrolls in the Qualified Medicare Beneficiary Program as defined in section 6408(d)(2) of the Federal Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, or full Medicaid (ARM 37.83.802), and no longer qualifies due to income or eligibility changes;

(i) the individual, upon first becoming eligible for benefits under Medicare Part A and B enrolls in the Montana Comprehensive Health Association and coverage under the Montana Comprehensive Health Association terminates; or

(j) the individual becomes eligible for benefits under Medicare Part A and B by reason of disability.

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

(b) an individual described in (2)(b), (c), (e), ~~or~~ (f), (h), or (i) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

(c) through (6)(b) remain the same.

AUTH: 33-1-313, 33-22-904, ~~33-2-905~~ 33-22-905, MCA
IMP: 33-22-902, 33-22-904, 33-22-905, MCA

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) through (4)(b)(iii) remain the same.

(iv) coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement, less any applicable copayments for advanced imaging services and power-operated vehicles or scooters, as described in (7)(c) and (7)(e) for new Plan C and F policies, or certificates with an effective date on or after January 1, 2015;

(v) and (vi) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA
IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

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 ON OR AFTER JUNE 1, 2010 (1) through (7)(c)(i) remain the same.

(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)~~.~~, with copayments in the following amounts for new policies and certificates with effective dates on or after January 1, 2015:

(A) the lesser of $25 or the Medicare Part B coinsurance or copayment for each primary covered advanced imaging service; and

(B) the lesser of $50 or the Medicare Part B coinsurance or copayment for the purchase of each covered power operated vehicle or scooter.

(iii) for purposes of this subsection:

(A) "advanced imaging service" means those Medicare Part B services, such as magnetic resonance imaging scans (MRIs), computerized tomography scans (CAT or CT scans) and positron emission tomography scans (PET scans), defined in separate guidance by the NAIC, in consultation with CMS, for purposes of establishing which covered services are subject to cost sharing. This definition may be updated periodically as needed; and

(B) "power operated vehicle" or "scooter" means certain durable medical equipment defined in separate guidance by the NAIC, in consultation with CMS, for purposes of establishing which covered services are subject to cost sharing. This definition may be updated periodically as needed.

(7)(d) through (7)(e)(i) remain the same.

(ii) 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign county, established in ARM 6.6.507D(4)(b)~~.~~, with copayments in the following amounts for the new policies and certificates with effective dates on or after January 1, 2015:

(A) the lesser of $25 or the Medicare Part B coinsurance or copayment for each primary covered advanced imaging service; and

(B) the lesser of $50 or the Medicare Part B coinsurance or copayment for the purchase of each covered power-operated vehicle or scooter where the supplier accepts Medicare assignment for the claim.

(iii) for purposes of this subsection:

(A) "advanced imaging service" means those Medicare Part B services, such as magnetic resonance imaging scans (MRIs), computerized tomography scans (CAT or CT scans) and positron emission tomography scans (PET scans), defined in separate guidance by the NAIC, in consultation with CMS, for purposes of establishing which covered services are subject to cost-sharing. The definition may be updated periodically as needed; and

(B) "power-operated vehicle" or "scooter" means certain durable medical equipment defined in separate guidance by the NAIC, in consultation with CMS, for purposes of establishing which covered services are subject to cost-sharing. This definition may be updated periodically as needed.

(7)(f) through (7)(f)(i)(B) remain the same.

(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. Copays for advanced imaging services and power-operated vehicles applied under regular Plan F for new policies issued on or after January 1, 2015, are not applicable under Plan F With High Deductible.

(7)(g) through (11) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA
IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

6.6.509 REQUIRED DISCLOSURE PROVISIONS (1) through (9)(b) remain the same.

~~(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 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed $2000. 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] Out of Pocket Annual Limit***	$[2310] 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]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; 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] deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses exceed [$2000]. 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) The CSI adopts and incorporates by reference the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, page 651-56 through page 651-106, which sets forth the Medicare payment tables for insurers, and specifically in this rule are the Outlines of Medicare Supplement Coverage-Cover Page: 1 of 2: Benefit Plan(s) A, B, C, D, E, F, G, H, I, J, and High Deductible Plans F & J; Outline of Medicare Supplement Coverage - Cover Page 2: Benefit Plan(s) K, L, M & N, which include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels, adopted 7/17/09. Copies of the NAIC Model rule containing Plans A - N are available for public inspection at the Office of the Commissioner of Securities and Insurance, Montana State Auditor, Legal Department, 840 Helena Avenue, Helena, Montana 59601, or on the department's web site. Persons obtaining a copy of these forms must pay the cost of providing such copies.

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

AUTH: 33-1-313, 33-22-904, 33-22-907, MCA
IMP: 33-15-303, 33-22-902, 33-22-904, 33-22-907, MCA

6.6.511 SAMPLE FORMS OUTLINING COVERAGE (1) through (2) remain the same.

~~(a)~~ ~~COVER PAGE~~
~~PREMIUM INFORMATION [boldface type]~~

~~We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]~~

~~DISCLOSURES [boldface type]~~

~~Use this outline to compare benefits and premiums among policies.~~
~~This outline shows benefits and premiums of policies sold for with an effective dates prior to June January 1, 20102015. Policies sold for with an effective dates prior to January 1, 2015, have different benefits and premiums.~~

~~READ YOUR POLICY VERY CAREFULLY [boldface type]~~

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [boldface type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [boldface type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [boldface type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan, prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to ARM 6.6.507A(4).]

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

(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			$[6.6.511(1)(a)] (Part A deductible)
First 60 days	All but $[6.6.511(1)(a)]	$0	
61st thru 90th day	All but $[6.6.511(1)(b)] a day	$[6.6.511(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:		100% of Medicare eligible expenses	$0**
- Additional 365 days	$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	$0	Up to $[6.6.511(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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
- First $[135] of Medicare - approved amounts*	$0	$0	$[135] (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] of Medicare - approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (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 $[6.6.511(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:		100% of Medicare eligible expenses	
Additional 365 days	$0		$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	$0	Up to $[6.6.511(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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	$0	Balance

**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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
- First $[135] of Medicare - approved amounts*	$0	$0	$[135] (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] of Medicare - approved amounts*	$0	$0	$[135] (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] of Medicare - approved amounts*	$0	$0	$[135] (Part B deductible)
- Remainder of Medicare - approved amounts	80%	20%	$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 $[6.6.511(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 Beyond the additional 365 days	$0 $0	100% of Medicare eligible expenses $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 out-patient drugs and inpatient respite care	$0	Balance

**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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

*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 $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (Part A deductible)	$0
61st thru 90th day	All but $[6.6.511(1)(a)] 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 D

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

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

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

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[135] of Medicare approved amounts*	$0	$0	$[135] (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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[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:		100% of Medicare	
--Additional 365 days	$0	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			
	All approved amounts	$0	$0
First 20 days	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
21st thru 100th day 101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
- First $[135] of Medicare -- approved amounts*	$0	$0	$[135] (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] of Medicare - approved amounts*	$0	$0	$[135] (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] of Medicare -- approved amounts*	$0	$0	$[135] (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 Additional charges	 $0 $0	 $120 $0	 $0 All costs

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

(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] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[2000]. 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] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2000] 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 Beyond the additional 365 days	$0	100% Medicare eligible expenses	$0***
	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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] 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] deductible. Benefits from the high deductible Plan F will begin until out-of-pocket expenses are $[2000]. 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] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] 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] of - Medicare approved - amounts* Remainder of - Medicare approved - Amounts	 $0 Generally 80%	 $[135] (Part B deductible) Generally 20%	 $0 $0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD First 3 pints Next $[135] of Medicare - approved amounts* Remainder of Medicare - approved amounts	$0 $0 80%	All costs $[135] (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] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] 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] of - Medicare approved amounts*	$0	$[135] (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] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] 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

*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 $[6.6.511(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 ---Once lifetime reserve days are used:	All but $[6.6.511(1)(c)] a day	$[6.6.511(1)(c)] a day	$0
---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 G

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

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

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

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary — skilled care services and — medical supplies	100%	$0	$0
— Durable medical equipment — First $[135] of Medicare — approved amounts*	$0	$0	$[135] (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

*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 $[6.6.511(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 H

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

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

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

(j) PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
- First 60 days	All but $[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

PLAN I

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

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

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

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] of Medicare approved amounts*	$0	$0	$[135] (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] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[2000]. 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] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO [$2000] 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

PLAN J or HIGH DEDUCTIBLE PLAN J

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

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for 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] 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] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $[2000]. 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] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] 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] of -Medicare approved -amounts*	$0	$[135] (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] of Medicare -approved amounts*	$0	All costs $[135] (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] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] 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] of Medicare -approved amounts*	$0	$[135] (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] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA - First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare - First $120 each calendar year - Additional charges	$0 $0	$120 $0	$0 All costs

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

(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] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $[6.6.511(1)(a)]	$[6.6.511(1)(a)] (50% of Part A deductible)	$[6.6.511(1)(e)]♦
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

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

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] of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (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])*
BLOOD First 3 pints	$0	50%	50%♦
Next $[135] of Medicare approved amounts*	$0	$0	$[135] (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] 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] of Medicare approved amounts*****	$0	$0	$[135] (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] 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 $[6.6.511(1)(a)]	$[6.6.511(1)(f)] (75% of Part A deductible)	$[6.6.511(1)(g)] 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

PLAN L

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

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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare approved amounts****	$0	$0	$[135] (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])*
BLOOD First 3 pints Next $[135] of Medicare approved amounts**** Remainder of Medicare Approved amounts	$0 $0 Generally 80%	75% $0 Generally 15%	25%♦ $[135] (Part B deductible) 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] 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] of Medicare approved amounts*****~~	~~$0~~	~~$0~~	~~$[135] (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.~~

(3) The CSI adopts and incorporates by reference the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, page 651-56 through page 651-106, which sets forth the Medicare payment tables for insurers, and specifically in this rule are Plans A, B, C, D, E, F or High Deductible F, G, H, I, J or High Deductible J, K, L, Medicare Part A - Hospital Services - Per Benefit Period; Plans A, B, C, D, E, F or High Deductible F, G, H, I, J or High Deductible J, K, L, Medicare Part B - Medical Services - Per Calendar Year; Plans A, B, C, D, E, F or High Deductible F, G, H, I, J or High Deductible J, K, L, Medicare Parts A & B; Plans C, D, E, F or High Deductible F, G, H, I, J or High Deductible J, Other Benefits - Not Covered by Medicare; adopted 7/17/09. Copies of the NAIC Model rule containing Plans A - L are available for public inspection at the Office of the Commissioner of Securities and Insurance, Montana State Auditor, Legal Department, 840 Helena Avenue, Helena, Montana 59601, or on the department's web site. Persons obtaining a copy of these forms must pay the cost of providing such copies.

AUTH: 33-1-313, 33-22-904, MCA
IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

6.6.511A SAMPLE FORMS OUTLINING COVERAGE (1) through (2) remain the same.

~~(a) COVER PAGE~~

~~PREMIUM INFORMATION [boldface type]~~

~~We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]~~

~~DISCLOSURES [boldface type]~~

~~Use this outline to compare benefits and premiums among policies.~~

~~This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J, are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]~~

~~READ YOUR POLICY VERY CAREFULLY [boldface type]~~

~~This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.~~

~~RIGHT TO RETURN POLICY [boldface type]~~

~~If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.~~

~~POLICY REPLACEMENT [boldface type]~~

~~If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.~~

~~NOTICE [boldface type]~~

~~This policy may not fully cover all of your medical costs.~~

~~[for agents:]~~

~~Neither [insert company's name] nor its agents are connected with Medicare.~~

~~[for direct response:]~~

~~[insert company's name] is not connected with Medicare.~~

~~This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for more details.~~

~~COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]~~

~~When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]~~

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan, prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments, and insured payments for each plan, using the same language in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this rule. An issuer may use additional benefit plan designations on these charts pursuant to ARM 6.6.507A(4).]

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

(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: —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	$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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare-approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (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:		100% of Medicare eligible expenses	
Additional 365 days	$0		$0**
Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
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 B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (Part B deductible)
- Remainder of Medicare approved amounts	80%	20%	$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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

(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 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 D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (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] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[2000]. 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] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2000] 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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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] 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] deductible. Benefits from the high deductible Plan F will begin until out-of-pocket expenses are $[2000]. 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] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] 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] of - Medicare approved - amounts*	$0	$[135] (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] of Medicare - approved amounts*	$0	$[135] (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] DEDUCTIBLE,**] PLAN PAYS~~	~~[IN ADDITION TO $[2000] 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] of~~ ~~- Medicare approved amounts*~~	~~$0~~	~~$[135] (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] DEDUCTIBLE,**] PLAN PAYS~~	~~[IN ADDITION TO $[2000] 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		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 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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

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

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 - - Durable medical equipment - - First $[135] of Medicare - - approved amounts* Remainder of Medicare - - approved amounts	100% $0 80%	$0 $0 20%	$0 $[135] (Part B deductible) $0

PLAN G

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] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $[6.6.511A(1)(a)]	$[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

PLAN K

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

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	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of 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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare approved amounts* Preventive benefits for Medicare covered services Remainder of Medicare approved amounts	 $0 Generally 75% or more of Medicare approved amounts Generally 80%	 $0 Remainder of Medicare approved amounts Generally 10%	 $[135] (Part B deductible)**** All costs above Medicare approved amounts Generally 10%♦
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4620])*
BLOOD First 3 pints Next $[135] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 Generally 80%	50% $0 Generally 10%	50%♦ $[135] (Part B deductible)****♦ 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] 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] of Medicare approved amounts*****	$0	$0	$[135] (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] 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

PLAN L

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

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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, - First $[135] of - Medicare approved - amounts****	$0	$0	$[135] (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])*
BLOOD First 3 pints	$0	75%	25%♦
Next $[135] of Medicare - approved amounts****	$0	$0	$[135] (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] 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] of Medicare approved amounts*****	$0	$0	$[135] (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		$[6.6.511A(1)(e)] (50% of Part A deductible)	$[6.6.511A(1)(e)] (50% of Part A deductible)
First 60 days	All but $[6.6.511A(1)(a)]		
61st through 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:		100% of Medicare eligible expenses	
Additional 365 days	$0		$0**
Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 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 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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (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] of Medicare approved amounts*	$0	$0	$[135] (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)]	$[6.6.511A(1)(a)] (Part A deductible)	$0
61st through 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 through 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

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

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] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.~~

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

(3) The CSI adopts and incorporates by reference the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, page 651-56 through page 651-106, which sets forth the Medicare payment tables for insurers, and specifically in this rule are Plans A, B, C, D, F or High Deductible F, G, K, L, M, and N - Medicare Part A - Hospital Services - Per Benefit Period; Plans A, B, C, D, F or High Deductible F, G, K, L, M, and N - Medicare Part B - Medical Services - Per Calendar Year; Plans A, B, C, D, F or High Deductible F, G, K, L, M and N - Medicare Parts A & B; Plans C, D, F or High Deductible F, G, M and N - Other Benefits Not Covered by Medicare; adopted 7/17/09. Copies of the NAIC Model rule containing Plans A - N are available for public inspection at the Office of the Commissioner of Securities and Insurance, Montana State Auditor, Legal Department, 840 Helena Avenue, Helena, Montana 59601, or on the agency's web site. Persons obtaining a copy of these forms must pay the cost of providing such copies.

AUTH: 33-1-313, 33-22-904, MCA
IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-924, MCA

4. STATEMENT OF REASONABLE NECESSITY: The Commissioner of Securities and Insurance, Montana State Auditor, Monica J. Lindeen, (Commissioner) is the statewide elected official responsible for administering the Montana Insurance Code and regulating the business of insurance.

The Commissioner is a member of the National Association of Insurance Commissioners (NAIC). The NAIC is an organization of insurance regulators from the 50 states, the District of Columbia, and the U.S. Territories. The NAIC provides a forum for the development of uniform policy and regulation when uniformity is appropriate.

It is necessary to amend these rules to reflect changes in the Federal regulations that were adopted in the NAIC Medicare Supplement Model Regulation. The changes in ARM 6.6.507D and 6.6.507E are taken exactly from the NAIC model regulation. The CSI adopts and incorporates all tables by reference to the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, page 651-56 through page 651-106, which sets forth the Medicare payment tables for insurers. Such incorporation is necessary because the data contained in these tables adjusts on a recurring basis to account for factors such as inflation. A copy of the NAIC Model Rule may be obtained from the CSI.

The rule change in ARM 6.6.507B(1)(b) is necessary to prevent persons currently enrolled in a supplemental program to Medicare from losing supplemental coverage should the program cease. This change is necessary to ensure persons on Medicare are treated equally, whether they be on Medicare by reason of age or disability.

The rule change in ARM 6.6.507C is necessary to extend Medicare supplement coverage to individuals who previously qualified for comparable coverage under another program but who became ineligible due to program termination or other reasons. Additionally, the change is necessary to ensure persons eligible for Medicare Part A and B are treated equally with regard to Medicare supplement coverage, regardless of the reason for Medicare Part A or B eligibility.

5. Concerned persons may submit their data, views, or arguments concerning the proposed actions either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Brett O'Neil, Attorney, Office of the Commissioner of Securities and Insurance, Montana State Auditor, 840 Helena Ave., Helena, Montana, 59601; telephone (406) 444-2040; fax (406) 444-3499; or e-mail BO'Neil@mt.gov, and must be received no later than 5:00 p.m., August 27, 2013.

6. Christina L. Goe, General Counsel, has been designated to preside over and conduct this hearing.

7. The CSI maintains a list of concerned 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 and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Such written request may be mailed or delivered

to Darla Sautter, Office of the Commissioner of Securities and Insurance, Montana State Auditor, 840 Helena Ave., Helena, Montana, 59601; telephone (406) 444-2726; fax (406) 444-3499; or e-mail dsautter@mt.gov, or may be made by completing a request form at any rules hearing held by the CSI.

8. 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.

9. Pursuant to 2-4-302, MCA, the bill sponsor contact requirements do not apply.

10. Pursuant to Chapter 318, Section 1, Laws of 2013, the Small Business Impact Analysis statement does not apply to these rules.

/s/Brett O'Neil	/s/Jesse Laslovich
Brett O'Neil	Jesse Laslovich
Rule Reviewer	Chief Legal Counsel

Certified to the Secretary of State July 15, 2013.

BEFORE THE FISH AND WILDLIFE COMMISSION
OF THE STATE OF MONTANA

In the matter of the adoption of New Rule I pertaining to salvage permits	)	NOTICE OF PROPOSED ADOPTION
	)	NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On November 14, 2013, the Fish and Wildlife Commission (commission) proposes to adopt the above-stated rule.

2. The commission 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 department no later than 5:00 p.m. on August 9, 2013, to advise us of the nature of the accommodation that you need. Please contact Jessica Snyder, Department of Fish, Wildlife and Parks, PO Box 200701, Helena, Montana, 59620-0701; telephone (406) 444-9785; fax (406) 444-7456; or e-mail jesssnyder@mt.gov.

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

NEW RULE I SALVAGE PERMITS (1) A deer, elk, moose, or antelope accidentally killed as a result of a vehicle collision may be salvaged and possessed if a permit is obtained from a peace officer.

(2) Any carcass taken for salvage must:

(a) be presented to a peace officer or department regional office during regular business hours within 24 hours of taking possession of the animal; and

(b) be disposed of in accordance with 75-10-213, MCA, and any meat rendered must be utilized for human consumption and may not be used for bait or any other purpose.

(3) The salvage permit will be issued on a form provided by the department.

(4) Big game tags and licenses issued for the purpose of hunting shall not be used for purposes of salvaging animals.

AUTH: 87-3-145, MCA
IMP: 87-1-301, 87-3-145, MCA

Reasonable Necessity: In 2013, HB 247 provided for individuals to be able to salvage deer, antelope, moose, and elk that were killed in vehicular collisions and provided authority for the commission to create rules to implement this action.

4. Concerned persons may submit their data, views, or arguments concerning the proposed action in writing to: Proposed Wildlife Salvage Rule, Law Enforcement Division, Department of Fish, Wildlife and Parks, PO Box 200701,

Helena, Montana, 59620-0701; fax (406) 444-7894; or e-mail comment@mt.gov, and must be received no later than August 23, 2013.

5. If persons who are directly affected by the proposed actions 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 the Law Enforcement Division at the above address no later than August 23, 2013.

6. If the agency receives requests for a public hearing on the proposed action from either 10 percent 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 more than 25 based on the number of drivers on Montana roads.

7. The department maintains a list of interested persons who wish to receive notice of rulemaking actions proposed by the department or commission. Persons who wish to have their name added to the list shall make written request that includes the name and mailing address of the person to receive the notice and specifies the subject or subjects about which the person wishes to receive notice. Such written request may be mailed or delivered to Fish, Wildlife and Parks, Legal Unit, PO Box 200701, 1420 East Sixth Avenue, Helena, MT 59620-0701, faxed to the office at (406) 444-7456, or may be made by completing the request form at any rules hearing held by the department.

8. The bill sponsor contact requirements of 2-4-302, MCA, apply and have been fulfilled. The primary bill sponsor was contacted by e-mail on July 15, 2013.

9. With regard to the requirements of Chapter 318, Section 1, Laws of 2013, the commission has determined that the adoption of the above-referenced rule will not significantly and directly impact small businesses.

/s/ Dan Vermillion
Chairman
Fish and Wildlife Commission

/s/ Zach Zipfel
Zach Zipfel
Rule Reviewer

Certified to the Secretary of State July 15, 2013.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the adoption of NEW RULE I concerning large-stakes card game tournaments, NEW RULE II concerning small-stakes card game tournaments, and amendment of ARM 23.16.102, 23.16.103, 23.16.107, 23.16.110, 23.16.401, 23.16.407, 23.16.502, 23.16.1101, 23.16.1201, 23.16.1216, 23.16.1224, 23.16.1225, 23.16.1232, 23.16.1237, 23.16.1240, 23.16.1701, 23.16.1702, 23.16.1703, 23.16.1704, 23.16.1705, 23.16.1712, 23.16.1713, 23.16.1714, 23.16.1716, 23.16.1719, 23.16.1826, 23.16.1826A, 23.16.1906, 23.16.1913, 23.16.1914, 23.16.1915, 23.16.1916, 23.16.1916A, 23.16.1918, 23.16.1929, 23.16.2001, and 23.16.3103 concerning grounds for denial of gambling license, permit or authorization; confiscation of temporary dealer license; card game tournament rules; how to acquire the official Montana poker rule book; player restrictions; dealer restrictions; house players; operation of the games – table stakes; betting; posting of rules and pot limits; definitions; sports pool cards; maximum price of sports pool chances; determination of sports pool winners – prizes; authorized sports pool prize value; sports tab game conduct; maximum price of sports tab; sports tab game prize value; sports tab game seller record keeping requirements – decal inventories; quarterly reporting requirements; reporting frequency for approved Tier I automated accounting systems; general software specifications for video gambling machines; testing fees; repairing machines – approval; casino night prizes; and web site address access	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT

to forms)

TO: All Concerned Persons

1. On August 15, 2013, at 9:00 a.m., the Montana Department of Justice will hold a public hearing in the conference room at the Gambling Control Division, 2550 Prospect Avenue, Helena, Montana, to consider the proposed adoption and amendment of the above-stated rules.

2. The Department of Justice 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 Department of Justice no later than 5:00 p.m. on August 9, 2013, to advise us of the nature of the accommodation that you need. Please contact Rick Ask, Administrator, Gambling Control Division, 2550 Prospect Avenue, P.O. Box 201424, Helena, Montana, 59620-1424; telephone (406) 444-1971; fax (406) 444-9157; Montana Relay Service 711; or e-mail rask@mt.gov.

3. The proposed new rules provide as follows:

NEW RULE I LARGE-STAKES CARD GAME TOURNAMENTS (1) A licensed operator with a permit to operate at least one live card game table on premises may apply to the department for an annual permit to conduct large-stakes card game tournaments. The application must be submitted on Form 14A, the large-stakes card game tournament permit application, which is available from the department. The annual permit fee must accompany the submission of the application. A large-stakes card game tournament permit is effective July 1 through June 30.

(2) A licensed operator who has been issued a large-stakes card game tournament permit may conduct no more than 16 large-stakes poker tournaments during the permit year.

(3) A large-stakes card game tournament may be conducted for no more than five consecutive days.

(4) The only consideration that may be paid by a participant in a large-stakes card game tournament is an entry fee, and if allowed by tournament rules, a fee paid to reenter the tournament after the participant has been eliminated from competition. Under no circumstances may the total amount paid to participate in a large-stakes card game tournament, including all entry and reentry fees, exceed $1,875.

(5) The department must receive notification on Form 14A of each large-stakes card game tournament at least five business days before the start of the tournament. The permit holder may submit the complete notification Form 14A to the department by mail, FAX or e-mail. The notification of a large-stakes card game tournament must state:

(a) permit holder’s name and operator’s license number;

(b) type of card game to be played;

(c) number of tables to be used during the tournament;

(d) date(s) of the tournament;

(e) amount of entry fee and reentry fees;

(f) description of all prizes, including the amount of any cash prizes;

(g) whether it is a charitable tournament, including identification of all charitable beneficiaries;

(h) whether it is part of a progressive tournament, including identification of all other locations participating in the progressive tournament;

(i) the face value of the chips to be used; and

(j) a copy of all tournament rules not included in the Poker Tournament Directors Association Rules.

(6) The department will mail the licensee a permit for each approved large-stakes card game tournament. The large-stakes card game permit must be conspicuously posted in the same manner as the tournament rules posted as provided for in 23-5-317, MCA.

(7) A large-stakes card game tournament permit holder may conduct a large-stakes card game tournament for charitable purposes.

(a) Any large-stakes card game tournament held for charitable purposes must be publicly identified as a charitable tournament and the beneficiaries of the tournament must be publicly identified before the start of the tournament.

(b) If a large-stakes card game tournament permit holder conducts large-stakes card game tournaments for charitable purposes, the first three charitable tournaments conducted during a permit year will not be deducted from the permit holder's annual 16-tournament limit.

(c) If a large-stakes card game tournament is publicly identified as a charitable tournament, no less than 50% of the total of all entry and reentry fees must be paid to charitable, educational, or recreational nonprofit organization(s).

(8) A large-stakes card game tournament may be part of a progressive card game tournament in which the ultimate prize is not awarded until completion of the final round of the progressive tournament.

(a) The tournament must be publicly identified as being part of a progressive tournament prior to initiation of the tournament.

(b) Each location that participates in the progressive tournament must obtain a large-stakes card game tournament permit.

(c) If the tournament is part of a progressive tournament, prize(s) may include the right to participate in the higher level of tournament play, so long as the value of the higher level tournament is equal to the value of the expected top prize in the tournament.

AUTH: 23-5-115, MCA
IMP: 23-5-317, MCA

RATIONALE AND JUSTIFICATION: The 2013 Legislature enacted HB 141, which in part authorized the creation of a two-tiered permit system for live card game tournaments, designated as "large-stakes" and "small-stakes" tournaments. Prior law required licensed operators to file an application and pay a permit fee for each live card game tournament conducted, up to a total of 12 tournaments per year. The new law requires licensed operators to apply for annual permits to conduct live card game tournaments. By law, the type of permit required will depend on the amount of

entry fees authorized by the individual tournament rules. Unlike the small-stakes tournaments, the large-stakes tournaments will require individual notification to, and approval from, the department.

This new rule is reasonable and necessary to formulate the operational framework for permitting and regulating these new large-stakes tournaments. This rule creates a new "Form 14A" to be used by operators to apply for the annual large-stakes tournament permit. Further, because of the limited number of large-stakes tournaments an operator may conduct each year, the law requires the permit holder to give the department prior notification for each large-stakes tournament. The rule instructs the operator to utilize the same large-stakes permit application form to notify the department of each proposed large-stakes tournament. The rule also informs the large-stakes permit holder of the information that must be included in the notification form, and the alternative methods for submitting the notification form to the department.

The department must receive prior notice for each proposed large-stakes tournament in order to approve the proposed tournament rules. The prior notice is necessary for the department to maintain a running tally of the number of large-stakes tournaments conducted each year for each permit holder. This tally must include those tournaments designated as charitable, since the first three charitable tournaments are not to be counted against the total number of authorized large-stakes tournaments.

Pursuant to this rule, the department will mail to the operator a copy of an individual permit for each large-stakes tournament to be conducted. This individual permit will notify the operator that the department has received and approved the tournament notification, and it will inform the operator of the department's tally of the number of large-stakes permits approved for that operator during the permit year. Additionally, the conspicuously posted permit will notify players, investigators or other law enforcement officials, that the tournament being conducted on the premises has been approved by the department as a large-stakes tournament.

NEW RULE II SMALL-STAKES CARD GAME TOURNAMENTS (1) A licensed operator with a permit to operate at least one live card game table on premises may apply to the department for an annual permit to conduct small-stakes card game tournaments. The application must be submitted on Form 14B, the small-stakes card game tournament permit application, which is available from the department. The annual permit fee must accompany the submission of the application. The small-stakes card game tournament permit is effective July 1 through June 30.

(2) The only consideration that may be paid to participate in a small-stakes card game tournament is a single entry fee which must be paid before the start of the tournament, and may under no circumstances exceed $80. No other fees or costs may be assessed to participate in a small-stakes tournament.

(3) Small-stakes card game tournaments may only be conducted on permitted card tables, plus one additional card table used only for small-stakes tournament play.

AUTH: 23-5-115, MCA

IMP: 23-5-317, MCA

RATIONALE AND JUSTIFICATION: As noted under New Rule I, the 2013 Legislature enacted HB 141, which in part authorized the creation of a two-tiered permit system for live card game tournaments – "large-stakes" and "small-stakes" tournaments. By law, the type of permit required will depend on the amount of entry fees authorized by the individual tournament rules.

The new law creates an annual small-stakes permit which will allow operators of permitted live card tables to conduct daily live card game tournaments where the total cost to enter the tournament does not exceed $80. Unlike the large-stakes tournaments, an operator who holds a small-stakes live card game tournament will not provide prior notification to, or receive individual tournament approval from, the department for each small-stakes tournament conducted by the permit holder. This new rule is therefore reasonable and necessary to create the operational framework for permitting and regulating these new small-stakes tournaments. It creates a new "Form 14B" for applying for the small-stakes tournament permits, and instructs operators how to apply to the department for the annual small-stakes tournament permit.

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

23.16.102 APPLICATION FOR GAMBLING LICENSE - LICENSE FEE

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

(4) Forms 10 and FD-258 are available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming.

(5) remains the same.

AUTH: 23-5-112, 23-5-115, 23-5-621, MCA
IMP: ~~16-4-414,~~ 23-5-115, 23-5-118, 23-5-128, 23-5-129, 23-5-177, 23-5-178, 23-5-308, 23-5-324, 23-5-513, 23-5-625, ~~23-5-637,~~ MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification purposes only; no substantive changes are intended.

23.16.103 INVESTIGATION OF APPLICANTS, FINGERPRINTS TO BE REQUIRED - DISCLOSURE FROM NONINSTITUTIONAL LENDER (1) and (2) remain the same.

(3) The department may require any noninstitutional lender to complete a document (Form 13) authorizing examination and release of information and (Form 10) a personal history statement on the lender, fingerprints on a form provided by the department, as well as any contract, statement, or other document from the lender deemed necessary to assess the suitability of an applicant's funding source

as required in 23-5-176, MCA. The document must be signed and dated by the lender and attested to by a notary public. Forms 13, 10, and FD-258 are available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming.

AUTH: 23-5-115, MCA
IMP: ~~16-4-414,~~ 23-5-112, 23-5-115, 23-5-118, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended.

23.16.107 GROUNDS FOR DENIAL OF GAMBLING LICENSE, PERMIT, OR AUTHORIZATION (1) through (1)(h) remain the same.

(i) been voluntarily or involuntarily dissolved as ~~a corporation~~ an entity;

(j) through (2) remain the same.

AUTH: 23-5-112, 23-5-115, MCA
IMP: 23-5-115, 23-5-176, MCA

RATIONALE AND JUSTIFICATION: Because the department licenses a variety of legal entities (e.g., corporations, limited liability companies, limited liability partnerships, etc.), this rule amendment is reasonable and necessary to include a broader reference in order to include all legal entities, not just corporations, which are subject to the same qualifications for licensure, and whose licenses or permits are subject to denial or revocation when that entity has been dissolved by the Secretary of State.

23.16.110 ASSOCIATED GAMBLING BUSINESS LICENSE (1) through (2) remain the same.

(a) an application using Form 17, with special instructions, and Form FD-258, which are available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming;

(b) through (5) remain the same.

AUTH: 23-5-112, 23-5-115, 23-5-178, MCA
IMP: 23-5-115, 23-5-178, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended.

23.16.401 APPLICATION FOR DEALER LICENSE (1) and (2) remain the same.

(3) The application for a dealer license, Forms 4 and FD-258, are available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming.

AUTH: 23-5-112, 23-5-115, MCA
IMP: 23-5-115, 23-5-308, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended.

23.16.407 CONFISCATION OF TEMPORARY DEALER LICENSE

(1) remains the same.

(a) the holder of such license has been placed or remains in actual or constructive custody as a result of any felony or gambling-related misdemeanor and is awaiting trial on such criminal charges; or

(b) ~~the holder of such license has not affixed the certified mail receipt to the license as required by these rules; or~~

~~(c) a certified mail receipt is affixed to such license but displays no postmark as required by these rules; or~~

~~(d) the license has expired; or~~

~~(e)~~ the department, pursuant to ARM 23.16.203(1), has notified the holder of such a license of the department's intent to deny a permanent dealer license to the holder~~; or~~

~~(f) the department has returned an incomplete dealer license application and the applicant has not acted within 15 days of mailing by the department to correct the deficiency~~.

AUTH: 23-5-115, MCA
IMP: 23-5-115, 23-5-308, MCA

RATIONALE AND JUSTIFICATION: Prior to 2007, temporary card dealer licenses were obtained at local driver's license stations, and under the rules at that time, applicants for temporary licensure were required to attach to their temporary license a certified mail receipt for the purpose of demonstrating to an investigator or other law enforcement officer that the applicant had mailed their completed application to the department.

Due to some abuses of that process, the legislature in HB 190, L. 2007, amended 23-5-308, MCA, and as a result, the department made substantial amendments to the process in ARM 23.16.406, by which temporary card dealer licenses are obtained. Under current rule, an applicant for temporary card dealer licensure must personally appear before a department investigator to submit an application. As a result, the grounds for confiscation of a temporary card dealer license need not include a failure to abide by provisions of the superseded system. These amendments are therefore reasonable and necessary to harmonize the

administrative procedures for the confiscation of a temporary license to the requirements of current law and administrative rule.

23.16.502 APPLICATION FOR OPERATOR LICENSE (1) All applicants shall submit the following information on Forms 30 and FD-258, ~~as those forms read on December 1, 2005,~~ which are incorporated by reference and available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming:

(a) through (2) remain the same.

AUTH: 23-5-112, 23-5-115, MCA
IMP: ~~16-4-414,~~ 23-5-115, 23-5-118, 23-5-176, 23-5-177, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended. This amendment also omits reference to the forms' revision date, which will allow the department to revise forms as necessary without the need to amend the rules.

23.16.1101 CARD GAME TOURNAMENTS – POKER TOURNAMENT DIRECTORS ASSOCIATION RULES (1) remains the same.

(2) ~~If a licensed operator with a permit for operating at least one live card game table on its premises wishes to conduct a card game tournament, the operator shall submit an application to the department for a card game tournament permit. Form 14, the card game tournament permit application, is available from the department upon request. The application must include:~~

~~(a) licensed operator's name;~~
~~(b) operator license number;~~
~~(c) location of the card game tournament;~~
~~(d) type of game to be played;~~
~~(e) number of tables to be used during the tournament;~~
~~(f) date of the tournament;~~
~~(g) amount of entry fee;~~
~~(h) amount of cash prizes;~~
~~(i) $10 processing fee; and~~
~~(j) copy of the tournament rules, which must identify the face value of the chips to be used.~~

~~(3) The card game tournament application should be received by the department at least ten working days before the start of the tournament. The department may process an application received by FAX but shall not issue a permit on such an application until the fee is received by the department. An application may not receive approval if received by the department with less than ten working days before the start of the tournament.~~

Except where there is a conflict with state law, department rule, or the applicable authority references, all poker tournaments shall comply with the most recent version of the Poker Tournament Directors Association Rules. The Poker

Tournament Directors Association Rules may be obtained from the Gambling Control Division web site www.doj.mt.gov/gaming.

(4) remains the same but is renumbered (3).

~~(5)~~(4) ~~In a~~ Every card game tournament involving poker or panguingue~~, each card game~~ must be conducted by a licensed dealer as required in 23-5-309, MCA. In addition, a designated person, who may be one of the licensed dealers, must be present on the premises at all times during the tournament to oversee the conduct of the games and settle disputes.

~~(6) The only consideration that may be paid by a tournament participant is:~~

~~(a) an entry fee; and~~

~~(b) a fee paid to reenter the tournament after being eliminated from competition, if permitted to do so under tournament rules.~~

~~(7) Under no circumstances may the total amount paid by an individual, including entry and reentry fees, exceed $2,500 for tournament play.~~

~~(8) A card game tournament permitted under these rules may be part of a progressive card game tournament in which the ultimate prize is not awarded until completion of the final round of the progressive tournament.~~

~~(a) The tournament must be publicly identified as being part of a progressive tournament prior to initiation of the tournament.~~

~~(b) Each location that participates in the progressive tournament must obtain a card game tournament permit.~~

~~(c) If the tournament is part of a progressive tournament, prize(s) may include the right to participate in the higher level of tournament play, so long as the value of the higher level tournament is equal to the value of the expected top prize in the tournament.~~

~~(9)~~(5) ~~Winners are~~ All winners must be determined at the conclusion of the tournament based upon points or chips accumulated throughout the course of the tournament. Prizes may only be awarded at the conclusion of the tournament. Any determination of a winner or award of a prize concludes a tournament.

~~(10) A tournament may not be conducted for more than five consecutive days. Card games may not be conducted between the hours of 2 a.m. and 8 a.m. each day unless the hours for operating a live card game table have been extended by a city or county ordinance. An operator may conduct up to 12 card game tournaments per year.~~

~~(11) An operator's card game tournament permit must be posted and clearly visible to the public. The permit is specific to an operator and location.~~

~~(12) For any card game tournament that is represented as a charitable tournament, no less than 50% of the total of all entry and reentry fees must be paid to charitable, educational, or recreational nonprofit organization(s).~~

~~(13) For each card game tournament, the location operator shall maintain for a period of 12 months and must provide to the department upon request a record of all entry fees and reentry fees paid by each participant. In addition, if the tournament was represented as a charitable tournament, the location operator shall also maintain for a period of 12 months, and provide to the department upon request, a record of the distribution of the tournament proceeds.~~

~~(14)~~(6) No card game tournament may be conducted as any part of a casino night.

(7) Card game tournaments may not be conducted between the hours of 2 a.m. and 8 a.m. on any day unless the hours for operating a live card game table have been extended by a city or county ordinance.

(15) remains the same but is renumbered (8).

AUTH: 23-5-115, ~~23-5-311,~~ MCA
IMP: 23-5-306, ~~23-5-311,~~ 23-5-317, MCA

RATIONALE AND JUSTIFICATION: As noted under New Rule I and New Rule II, the 2013 Legislature enacted HB 141, which in part authorized the creation of a two-tiered permit system for live card game tournaments. The amendments proposed to this rule are necessary to reflect those changes in law, and the creation of New Rule I and New Rule II which are made to implement the new law. These proposed rule amendments leave intact those aspects of current tournament rules which apply to both large-stakes and small-stakes tournaments.

Additionally, as recommended by the Gaming Advisory Council, the department proposes to adopt in this rule a requirement that live poker tournaments adhere to the Poker Tournament Directors Association Rules to the extent they do not conflict with state law or administrative rules. This change is intended to implement statewide uniformity in many of the rules of conduct for poker tournaments.

23.16.1201 DEFINITIONS As used throughout this subchapter, the following definitions apply:

(1) remains the same.

(2) "Authority reference" means Official Montana Poker Rulebook ~~(1990 Edition)~~ and Scarne's Encyclopedia of Card Games, copyright 1983, by John Scarne, pages 18 through 276. These books will be used by the department as the authority on how to play authorized card games. The authority references are adopted and incorporated by reference; copies of Scarne's Encyclopedia of Card Games may be obtained from local bookstores and copies of the Official Montana Poker Rulebook may be obtained ~~for $5.00 per copy~~ from the Gambling Control Division~~, 2550 Prospect Ave., P.O. Box 201424, Helena, Montana 59620-1424~~ web site www.doj.mt.gov/gaming. The sections of the books cited as authority will not apply where there is a conflict with state law or department rule.

(3) through (19) remain the same.

AUTH: 23-5-115, MCA
IMP: 23-5-115, 23-5-311, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public how they may obtain a copy of the Official Montana Poker Rulebook online and free of charge.

23.16.1216 PLAYER RESTRICTIONS (1) through (3) remain the same.

(4) No player or other person may provide any information to any other player or person regarding ~~the~~ a player's live or folded hand. ~~No person may provide any information to any other person regarding a player's live or folded hand.~~

(5) and (6) remain the same.

AUTH: 23-5-115, MCA
IMP: 23-5-311, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is proposed for clarification and ease of reading purposes only; no substantive changes are intended.

23.16.1224 DEALER RESTRICTIONS (1) ~~In~~ Except as provided in (3), in authorized card games using licensed dealers, licensed dealers shall have no financial interest, directly or indirectly, in the outcome of any game which they deal.

(2) and (3) remain the same.

AUTH: 23-5-115, MCA
IMP: 23-5-308, 23-5-309, 23-5-311, 23-5-324, MCA

RATIONALE AND JUSTIFICATION: This proposed amendment seeks to clarify that the restriction in (1) relating to a dealer's financial interest in the outcome of a game does not apply if the dealer is himself or herself the licensed operator or card room contractor who is conducting the game. This is current law and the proposed amendment is offered for clarification, consistency within the rule, and ease of reading.

23.16.1225 HOUSE PLAYERS (1) and (2) remain the same.

(3) No house players may be used by the operator or card room contractor in a card game tournament.

AUTH: 23-5-115, 23-5-325, ~~23-5-710,~~ MCA
IMP: 23-5-311, 23-5-324, 23-5-325, MCA

RATIONALE AND JUSTIFICATION: This proposed amendment is reasonably necessary to clarify that the authorized use of house players does not include tournaments. By rule, the use of house players is limited to starting or maintaining a sufficient number of players in a card game. Given the nature of tournaments, there is no valid reason that house players would be used. This rule is intended to clarify the role of house players and promote consistency throughout the rules.

23.16.1232 OPERATION OF THE GAMES –TABLE STAKES (1) remains the same.

(2) The operator or card room contractor may set a minimum buy-in, a maximum buy-in, or both, for each game. The operator or card room contractor

must announce the length of time a player may leave the game and still be considered part of the same playing session.

(3) through (7) remain the same.

AUTH: 23-5-115, MCA
IMP: 23-5-309, 23-5-311, 23-5-311, 23-5-312, 23-5-313, 23-5-324, MCA

RATIONALE AND JUSTIFICATION: During the Gaming Advisory Council's evaluation of live card games, some public comments addressed a problem occurring in live poker games where certain players with a bankroll larger than other players would immediately go all-in, which would typically cause all other players to fold. As a result, the games often devolved into what was termed "poker bingo," where the winning pot simply moved from one player to the next, depending on who went all-in, and as a result many players would lose interest and leave the table. In addition to increasing the maximum pot limits to address this problem, it was suggested that the department could establish by rule a requirement for table stakes in non-tournament poker games. A table stakes requirement would limit the amount of money (value in chips) a player could bring to a table to buy-in.

This rule currently recognizes that an operator or card room contractor may establish by house rule a minimum buy-in, which must be posted. This proposed amendment is therefore reasonable and necessary to clarify that an operator may also establish, by house rule, a maximum buy-in limit, as that may tend to level the playing field among the players. As proposed by this rule amendment, it will be left to the operator or card room contractor to determine whether or not to establish either a minimum buy-in limit, a maximum buy-in limit, or both such limits.

23.16.1237 BETTING (1) A player who unintentionally puts ~~less~~ fewer chips into the pot than are needed to call a bet must either complete the call or withdraw his or her chips and fold.

(2) If an improper number of chips are bet by a player and the dealer puts the player's chips into the pot without making or hearing an immediate objection, it must be considered a bet by the player.

(3) through (6) remain the same.

AUTH: 23-5-115, MCA
IMP: 23-5-309, 23-5-311, 23-5-312, 23-5-313, MCA

RATIONALE AND JUSTIFICATION: This proposed rule amendment is proposed for clarification and ease of reading purposes only; no substantive changes are intended.

23.16.1240 POSTING OF RULES (1) through (1)(d) remain the same.

(e) Minimum and/or maximum buy-in limits (if any).

(f) ~~$300~~ $800 pot limit.

(g) through (o) remain the same.

(p) ~~Players may request that house players be identified~~ House players identified upon request.

(2) remains the same.

AUTH: 23-5-115, MCA
IMP: 23-5-309, 23-5-312, 23-5-313, ~~23-5-324,~~ 23-5-325, MCA

RATIONALE AND JUSTIFICATION: The 2013 Legislature enacted HB 141, which in part increased the prize limit for an individual live card game from $300 to $800. The proposed amendment is necessary to harmonize the terms of this rule with the new law. The amendment also proposes changes which will coordinate with the amendments proposed to ARM 23.16.1232 to allow an operator to set a maximum buy-in limit, and makes other minor nonsubstantive changes in style for clarification and ease of reading purposes.

23.16.1701 DEFINITIONS As used throughout this subchapter, the following definitions apply:

(1) through (2)(b) remain the same.

(3) "Interval of a sporting event" means the regularly timed periods or naturally occurring breaks in a sports event established by the rules of the event (i.e., quarters in football and basketball games, periods in hockey, or innings in a baseball game) and not any other contrived point, action, event, or episode in the sports event.

(3) through (13) remain the same but are renumbered (4) through (14).

(15) "Total value of the sports pool" means an amount equal to the number of chances in a sports pool multiplied by the cost per chance and represents the prize(s) to be awarded.

AUTH: 23-5-115, 23-5-512, MCA
IMP: 23-5-501, 23-5-502, 23-5-503, 23-5-512, MCA

RATIONALE AND JUSTIFICATION: These proposed rule changes are reasonable and necessary to clarify by definition certain terms used in the administrative rules regarding sports tabs and sports pools. The proposed definition of an "interval of a sporting event" seeks to clarify when prizes may be awarded, rather than upon contrived events such as the first turnover of a game, the first fumbled ball, or every score, etc. The proposed definition of the term "total value of the sports pool" attempts to eliminate confusion about the value of the prize to be won. Some sports pools have an odd number of participants (e.g., NASCAR) where the prize money taken in does not always reach the level of the maximum allowed. Additionally, some sports pools are designed to award merchandise as the prize and this definition should help to enforce the rule which requires the operator to pay the winner the merchandise plus a cash balance if the purchase price of the merchandise is less than the total value of the sports pool.

23.16.1702 SPORTS POOL CARD (1) and (2) remain the same.

(3) A participant who wishes to purchase a chance on more than one traditional, series, or multiple way sports pool must select a space or spaces on each of the boards. After the sale of all chances, the master square of any such board may not be duplicated or altered in any manner so as to create additional sports pool boards.

(3) and (4) remain the same but are renumbered (4) and (5).

~~(5)~~(6) A sports pool card must be retained by the person conducting the sports pool ~~until all prizes are awarded or for 30 days after~~ for at least one year from the date of the sports event, or last event in a series of sports events, whichever occurs first, upon which the sports pool was based.

AUTH: 23-5-115, 23-5-512, MCA
IMP: 23-5-502, 23-5-503, 23-5-512, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is intended to clarify that sports pool boards may not be duplicated in any manner so as to increase wagers and payouts beyond the limits set by law. Each sports pool board must be sold separately and numbers must be randomly assigned to squares on each board separately. In the past, the department found some board operators who would sell one board and assign numbers to each square, then copy the board several times, and charge participants multiples of the maximum wager corresponding to the number of copies made, and advertise payouts at the same level of multiples of the maximum.

Additionally, the rule amendment proposes a records retention period that is consistent with the requirement for sports tabs in ARM 23.16.1715. Because of the 2013 Legislature's passage of HB199, which increased bets and payout for sports pools and sports tabs by 500%, sports pools and sports tabs will now be offering some of the largest gambling payouts in Montana. Therefore, this extended period of time for record retention will be critically important to maintain a record in the event a participant complains that a sports pool prize was not properly awarded. As this proposed retention period is consistent with the retention periods required for other gambling activities, it should not pose any special burden for the operator.

23.16.1703 SALE OF SPORTS POOL CHANCES (1) The total cost of a chance shall not exceed ~~$5~~ $25 per sports event, or $25 per sports event for a series sports pool as described in 23.16.1705(3)(b), and must be paid in full and in cash at the time the chance is selected.

(2) through (4) remain the same.

(5) All money paid to participate in a sports pool must be maintained separately from all other monies. No portion of the money collected in the sale of sports pool chances, including any share designated for charitable purposes, if any, may be separated from the total amount of proceeds collected on the sports pool board until after the sports event upon which the pool was based has occurred.

AUTH: 23-5-115, 23-5-512, MCA
IMP: 23-5-502, 23-5-503, 23-5-512, MCA

RATIONALE AND JUSTIFICATION: The 2013 Legislature enacted HB 199, which increased the bet and payout limits for sports pools and sports tabs by 500%. The proposed amendments are therefore necessary to harmonize the bet limits referenced in this rule with the new law.

Additionally, the rule amendment proposes to require the operators of sports pools keep the monies collected on the sports pool separate from other monies. This requirement will eliminate the comingling of monies paid on separate sports pools, which will assist investigators when they conduct premises inspections. Currently, some operators of sports pools collect the money paid by participants in the till, or in a common pot with other sports pools or other monies. This practice impedes an investigator's attempt to match the money collected on a sports pool with the number of participants marked as participating on the board. This frustrates a determination of whether or not the operator is allowing participants to play now and pay later, an unlawful credit gambling practice. This requirement will make a determination of sports board compliance easier and more accurate, particularly when an establishment offers multiple sports pools.

23.16.1704 DETERMINATION OF SPORTS POOL WINNERS - PRIZES

(1) remains the same.

(2) The prizes awarded to the winner or winners of a sports pool may be cash or merchandise but must not exceed a total value of ~~$500~~ $2,500 per sports event.

(a) Where the prize awarded is merchandise, the purchase price paid for the item(s) of the merchandise prize is considered to be the value of the prize. Proof of the purchase price of the item(s) of the merchandise prize shall be retained for a period of ~~30 days after~~ at least one year from the date of the sports event.

(b) and (3) remain the same.

(4) A nonprofit organization may retain up to 50 percent of the ~~value of~~ proceeds from the sale of chances in a sports pool if the ~~amount retained is used to support charitable activities, scholarships or educational grants, or community service activities. The nonprofit organization must maintain and open to inspection upon reasonable demand records to verify the use of the retained portion of the sports pool~~ nonprofit organization meets the requirements of 23-5-503, MCA.

AUTH: 23-5-115, MCA
IMP: 23-5-502, 23-5-503, 23-5-512, MCA

RATIONALE AND JUSTIFICATION: The 2013 Legislature enacted HB 199, which increased the bet and payout limits for sports pools and sports tabs by 500%. The proposed amendments are therefore necessary to harmonize the new prize limits with those referenced in this rule.

Additionally, the rule amendment proposes to require the operators of sports pools to maintain a record of the price paid for merchandise for a one-year period, which is a reasonable period of time. The proposed records retention period is identical to the records retention period required in ARM 23.16.1715 for proof of the price of the merchandise awarded in a sports tab game. The department has encountered operators of sports pools who were proposing to award prizes in

merchandise with less value than the total value of the sports pool. This requirement will assist investigators to ensure that the total value of a sports pool is paid to the winning participants.

The amendment also proposes other nonsubstantive changes in style for clarification and ease of reading purposes.

23.16.1705 AUTHORIZED SPORTS POOLS (1) through (3)(c) remain the same.

(d) A "selected point sports pool" in which the winner is the participant whose assigned competitor is the first to attain a final score that matches a predetermined number (e.g., 28, 39). If in a given week none of the competitor's scores match the predetermined number, the prize is carried over to the next and subsequent weeks until a match occurs. However, the pool must be designed to ensure that a prize does not exceed the value of ~~$500~~ $2,500. The number of participants in a selected point sports pool is limited to the number of competitors in an established league. Competitors are randomly assigned to the participants and may be assigned for a single week or the duration of the pool.

(e) through (g) remain the same.

AUTH: 23-5-115, 23-5-512, MCA
IMP: 23-5-502, 23-5-503, 23-5-512, MCA

RATIONALE AND JUSTIFICATION: The 2013 Legislature enacted HB 199, which increased the bet and payout limits for sports pools and sports tabs by 500%. The proposed amendment is therefore necessary to harmonize the new prize limits with those referenced in this rule.

23.16.1712 DESIGN AND CONDUCT OF SPORTS TAB GAME (1) through (5) remain the same.

(6) All money paid to participate in each sports tab game shall be kept separate from any other money. No share for charitable contributions or administrative expenses may be separated from the total amount collected until after the sports event has occurred.

AUTH: 23-5-115, MCA
IMP: 23-5-501, 23-5-503, MCA

RATIONALE AND JUSTIFICATION: This proposed rule amendment is necessary to require the sponsor of a sports tab game to keep the monies collected on the sports tab game separate from all other monies. Consistent with the proposed amendment to ARM 23.16.1703, this requirement will eliminate the comingling of monies paid on separate sports tab games (or from other sources), which will have the beneficial effect of assisting investigators when they conduct premises inspections. Currently, some operators will keep monies collected on a sporting event in the till, or in a common pot with wagers on other events. This practice makes it difficult for an investigator to determine whether all participants have paid to participate in the gambling activity. This requirement will make a

determination of compliance with the rules of sports tab games easier and more accurate.

23.16.1713 PURCHASE AND SALE OF SPORTS TABS BY SPONSOR – LICENSURE (1) and (2) remain the same.

(3) The total cost of each sports tab on the same sports tab card must be identical and may not exceed ~~$5~~ $25. A participant shall pay cash for the sports tab at the time the tab is selected.

(4) remains the same.

AUTH: 23-5-115, 23-5-178, MCA
IMP: 23-5-178, 23-5-502, 23-5-503, MCA

RATIONALE AND JUSTIFICATION: The 2013 Legislature enacted HB 199, which increased the bet and payout limits for sports pools and sports tabs by 500%. The proposed amendment is therefore necessary to harmonize the new bet limits for sports tab games with those referenced in this rule.

23.16.1714 SPORTS TAB GAME PRIZES (1) through (3) remain the same.

(4) The total value of all prizes awarded in a sports tab game may not exceed ~~$500~~ $2,500. Prizes must be in cash or merchandise.

(5) through (7) remain the same.

AUTH: 23-5-115, MCA
IMP: 23-5-502, 23-5-503, MCA

RATIONALE AND JUSTIFICATION: The 2013 Legislature enacted HB 199, which increased the bet and payout limits for sports pools and sports tabs by 500%. The proposed amendment is therefore necessary to harmonize the new prize limits for sports tab games with those referenced in this rule.

23.16.1716 SPORTS TAB GAME SELLER LICENSE (1) remains the same.

(a) a sports tab game seller license application. Form FD-258 is available upon request from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming;

(b) Form 10 as described in ARM 23.16.102, available upon request from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming;

(c) through (4) remain the same.

AUTH: 23-5-112, 23-5-115, MCA
IMP: 23-5-115, 23-5-502, 23-5-503, 23-5-513, MCA

RATIONALE AND JUSTIFICATION: These rule amendments are reasonable and necessary to inform licensees and the general public where license application

forms may be obtained online. These amendments are made for clarification and informational purposes only; no substantive changes are intended.

23.16.1719 SPORTS TAB GAME SELLER RECORD KEEPING REQUIREMENTS - DECAL INVENTORIES (1) remains the same.

(2) A sports tab game seller shall maintain records documenting the total number of sports tab cards sold, the sponsor, and the sports tab tax decal serial number as affixed to each sports tab game card by serial number. The sports tab game seller must maintain these records, and make the records available to the department upon request, for a minimum of 12 full quarters from the previous quarterly tax return due date. Such records shall document:

(a) the total number of sports tab games sold by referencing the sports tab game by game serial number and corresponding sports tab tax decal serial number ~~to the sponsor~~, including the sponsor's name, license number, address, and phone number; and

(b) the amount and serial numbers of sports tab tax ~~game~~ decals remaining in the sports tab game seller's possession.

(3) A sports tab game seller may not transfer sports tab tax decals to any person, except when affixed to a sports tab card. If sports tab game sellers wish to reduce their sports tab tax decal inventory, they may only return the decals to the department. If sports tab game sellers cease to sell sports tab games, they shall file, within 15 days following the date upon which they terminated sales, a report on a form provided by the department, remit any tax due, and return all unused sports tab tax decals.

(4) A sports tab game seller shall return any sports tab tax decals to the department upon request of the department.

AUTH: 23-5-115, MCA
IMP: 23-5-502, 23-5-503, MCA

RATIONALE AND JUSTIFICATION: In 2011, department investigators discovered certain abuses of the regulatory framework involving sports tab games, including specifically misuses of state sport tab tax decals. As a result of those abuses, as well as the 2013 Legislature's increase of sports tab game wagers and prize payouts by 500%, the department proposes to change the regulatory procedures for sports tab games through the use of serialized and bar-coded sport tab tax decals, which will improve the regulation of the sale of sports tabs and sports tab games.

Currently, the department issues state tax decals to licensed sports tab game sellers, who then affix the tax decals to sports tab game boards, and sell those game boards to operators (or licensed sponsors) who in turn sell the individual tabs to customers. However, the current tax decals are indistinct from one other, and department investigators are unable to determine who was issued a particular decal, or who may have affixed the sports tab tax decal to a particular sports tab board game.

As proposed by this rule amendment, a licensed sports tab game seller will be issued sports tab tax decals by serial number. The seller will then affix a tax

decal to a particular sports tab game board and record the serial numbers from each instrument. Through this procedure, an investigator will have the ability to determine whether the decal was legitimately issued by the department, whether the sports tab tax decal is affixed to the correct game board, and whether the game board was purchased from the licensed sports tab game seller on record.

23.16.1826 QUARTERLY REPORTING REQUIREMENTS (1) through (1)(b) remain the same.

(i) for tier I systems, all electronic meter readings and all events set out in ARM 23.16.2105 for each ~~week~~ day the machine is in operation, and the last set of meter readings received before the end of the quarter (meter readings received no more than seven days before the end of the quarter) will be used as quarter end readings for purpose of calculating a tax advisory to be sent to machine owners;

(ii) for tier II systems, all electronic meter readings for each week or two week period for which the machine is approved to report, and within 14 days prior to the end of the quarter but not later than seven days ~~of~~ after the last day of each quarter, all electronic and mechanical meter readings, along with an indication that it is the last reading to be reported in the quarter; and

(iii) through (2)(c) remain the same.

(3) Form 6 is a quarterly video gambling machine tax report; Form 6 is incorporated by reference and is available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming.

(4) through (6) remain the same.

AUTH: 23-5-115, ~~23-5-605,~~ 23-5-621, MCA
IMP: ~~23-5-115,~~ 23-5-136, 23-5-610, 23-5-621, 23-5-637, MCA

RATIONALE AND JUSTIFICATION: The department has authorized the use of automated accounting and reporting systems to record and communicate to the department, in electronic form, certain video gambling machine accounting information and records of video gambling machine events. Tier I is the most automated of the different types of automated accounting and reporting systems, and is only recently being introduced for use in this jurisdiction. This proposed amendment modifies the meter reporting frequency required for machines reporting on a Tier I system from each week to each day. This change is necessary to match the frequency of the reports for Tier 1 systems to correspond to the department business practices of clearing daily all reporting exceptions for machines reported on Tier I systems. Because these types of reports are automated through the Tier I system, the proposed change will have no adverse impact on operators who use that system.

The proposed rule amendment also proposes to change the reporting requirements for users of a Tier II automated accounting and reporting system. A Tier II system communicates video gambling machine record information to a state-sponsored internet site. Tier II is less automated and requires more manual handling of information than does a Tier I system. Some video gambling machine owners who report information on a Tier II system have machines in locations in

remote areas of the state, and may only visit those locations once every two weeks to gather meter data and maintain the machines. As result, those visits to gather the machine data fall outside the current reporting time frame required by this rule. The legislature authorized the use of automated accounting and reporting systems, in part, to lessen the administrative and record keeping burdens for licensed machine owners and the department. By this amendment, the department is extending the number of days before the end of the quarter during which meter data may be taken and reported. These proposed amendments are therefore necessary to reflect reporting time frames which meet the business realities for users of the Tier II systems. The department also notes that in the event some machine accounting information is not reported in the quarter due to the 14-day extension, that information will be reported in the succeeding quarter, and therefore the process reflected by the proposed amendments conforms to the department's current standards and reporting requirements.

Finally, the proposed amendment informs licensees and the general public where license application forms may be obtained online. This amendment to (3) is nonsubstantive and offered for clarification and informational purposes only.

23.16.1826A REPORTING FREQUENCY FOR APPROVED AUTOMATED ACCOUNTING SYSTEMS – EXCEPTIONS (1) Tier I systems shall transmit the information required by ARM 23.16.2105 ~~in seven~~ each day ~~reporting intervals~~.

(2) through (4) remain the same.

AUTH: 23-5-621, MCA
IMP: 23-5-610, 23-5-621, 23-5-637, MCA

RATIONALE AND JUSTIFICATION: As noted in the proposed amendments to ARM 23.16.1826, the department has authorized the use of automated accounting and reporting systems to record and communicate to the department in electronic form video gambling machine accounting information and records of video gambling machine events. A Tier I system is the most automated of the different types of reporting systems. However, a Tier I system does not capture and report any mechanical meters from the video gambling machines. In order to avoid a potential loss of meter data in the event of a system outage, it is critical that the department obtain daily electronic meter readings captured by the Tier I system.

This change is proposed so that the frequency of reports will match/provide the information necessary for the department business practices of clearing daily all reporting exceptions for machines reported on a Tier I system. Because the meter reports are completed automatically through a Tier I system, this rule amendment will have no adverse impact on licensed machine owners.

23.16.1906 GENERAL SOFTWARE SPECIFICATIONS FOR VIDEO GAMBLING MACHINES (1) remains the same.

(a) the random number selection process shall conform to an acceptable random order of occurrence and uniformity of distribution as defined by the department;

~~(b) the field of numbers must be mixed after each game by using a random number generator;~~

~~(c) after the field of numbers has been mixed and before the start of the game the field of numbers is to be frozen with all numbers used for play taken in order from the top of the frozen field;~~

(d) through (k) remain the same but are renumbered (b) through (i).

(2) through (4) remain the same.

AUTH: 23-5-115, ~~23-5-602,~~ 23-5-621, MCA
IMP: ~~23-5-111,~~ ~~23-5-112,~~ ~~23-5-115,~~ ~~23-5-151,~~ 23-5-602, 23-5-603, 23-5-607, 23-5-608, 23-5-611, 23-5-621, 23-5-631, 23-5-637, MCA

RATIONALE AND JUSTIFICATION: The proposed rule amendment is reasonable and necessary because the "field of numbers," as described in the current rule, does not exist in most modern random number generator (RNG) implementations. The proposed amendment allows the department to establish that the best practices of RNG processes to be defined and facilitated through published video gambling machine (VGM) requirements. VGM requirements are developed with input from VGM manufacturers, and posted on the department's web page.

23.16.1913 USE OF TEMPORARY REPLACEMENT OR LOANER MACHINES - PERMIT REQUIRED - REPORTING (1) remains the same.

(2) Any operator placing a temporary replacement machine in service must notify the department on a form prescribed by the department. An application to place a temporary replacement machine in service is incorporated by reference as Form 7 and is available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming.

(3) through (6) remain the same.

AUTH: 23-5-115, ~~23-5-603,~~ 23-5-621, MCA
IMP: 23-5-111, 23-5-603, 23-5-611, 23-5-612, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended.

23.16.1914 DISTRIBUTOR'S LICENSE (1) remains the same.

(a) a distributor's license application, Forms 17 and FD-258 are available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming;

(b) through (3) remain the same.

AUTH: 23-5-112, 23-5-115, MCA
IMP: 23-5-115, 23-5-128, 23-5-176, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended.

23.16.1915 ROUTE OPERATOR'S LICENSE (1) remains the same.

(a) a route operator license application, Forms 17 and FD-258 are available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming;

(b) through (3) remain the same.

AUTH: 23-5-112, 23-5-115, MCA
IMP: 23-5-115, 23-5-129, 23-5-176, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended.

23.16.1916 MANUFACTURER'S LICENSE (1) remains the same.

(a) a manufacturer's license application, Forms 17 and FD-258 are available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming;

(b) through (3) remain the same.

AUTH: 23-5-112, 23-5-115, MCA
IMP: 23-5-115, 23-5-176, 23-5-625, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended.

23.16.1916A ACCOUNTING SYSTEM VENDOR LICENSE (1) remains the same.

(a) application for an accounting system vendor license using Form 17, with special instructions, and Form FD-258 are available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming;

(b) through (3) remain the same.

AUTH: 23-5-112, 23-5-115, 23-5-178, 23-5-621, MCA
IMP: ~~23-5-110, 23-5-112,~~ 23-5-115, 23-5-178, 23-5-637, MCA

RATIONALE AND JUSTIFICATION: This rule amendment is reasonable and necessary to inform licensees and the general public where license application

forms may be obtained online. This amendment is made for clarification and informational purposes only; no substantive changes are intended.

23.16.1918 TESTING FEES (1) through (1)(b) remain the same.

(i) video gambling machines, ~~$3,000~~ $10,000;

(ii) automated accounting and reporting system, ~~$2,000~~ $15,000;

(iii) modification to an approved video gambling machine or automated accounting and reporting system, ~~$300~~ $1,000.

(2) and (3) remain the same.

AUTH: 23-5-115, 23-5-621, MCA
IMP: 23-5-631, 23-5-637, MCA

RATIONALE AND JUSTIFICATION: As required by 23-5-631, MCA, the manufacturers pay in advance the anticipated actual costs of video gambling machine examination. Deposit fees have not been amended since 2002. The average cost of testing and approving new and modified video gambling machine submissions typically now exceeds the current deposit required for such tests. Therefore, the proposed increase in fee deposits, as reflected in the proposed amendments to this rule, is necessary to bring the payment closer to the anticipated actual costs which are incurred in the machine and system testing based on the department's experience in the past ten years.

23.16.1929 REPAIRING MACHINES - APPROVAL (1) remains the same.

(2) Any repair or replacement of a machine's logic board which may cause a loss of memory, change in program name or revision, or change in the meter reading must be reported to the Gambling Control Division of the Department of Justice on forms prescribed by the department at the time of the repair. The report requires the disclosure of the following information:

(a) through (5) remain the same.

AUTH: 23-5-115, ~~23-5-605,~~ 23-5-621, MCA
IMP: 23-5-603, ~~23-5-605,~~ ~~23-5-606,~~ 23-5-616, 23-5-621, 23-5-631, MCA

RATIONALE AND JUSTIFICATION: In the past, issues have arisen from incorrect records of VGM program names because the department has not received notice of VGM program name or version changes. As proposed by this rule amendment, video gambling machine owners will be required to report a change in program name or version, even if there is no change in the meter readings. This amendment is necessary to make certain the department receives notification of all VGM program name changes or revisions, which results in a current record of the programs in the department's database.

23.16.2001 MANUFACTURER OF ILLEGAL GAMBLING DEVICES - LICENSE - FEE - REPORTING REQUIREMENTS - INSPECTION OF RECORDS - REPORTS (1) remains the same.

(a) a manufacturer license application, Form 17 is available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site www.doj.mt.gov/gaming;

(b) through (8) remain the same.

(9) Form 22 is available from the Gambling Control Division, 2550 Prospect Ave., P.O. Box 201424, Helena, MT 59620-1424, or on the department's web site ~~(www.doj.mt.gov/gaming/forms.asp)~~ www.doj.mt.gov/gaming.

AUTH: 23-5-112, 23-5-115, 23-5-152, 23-5-621, MCA
IMP: ~~23-5-112,~~ 23-5-115, 23-5-152, 23-5-611, 23-5-614, 23-5-621, 23-5-625, 23-5-631,MCA

RATIONALE AND JUSTIFICATION: These rule amendments are reasonable and necessary to inform licensees and the general public where license application forms may be obtained online. These amendments are made for clarification and informational purposes only; no substantive changes are intended.

23.16.3103 GENERAL REQUIREMENTS (1) through (1)(f) remain the same.

(g) ~~Only~~ Cash or merchandise may be awarded as prizes. The value of the merchandise is not restricted to the prize limitations provided for in 23-5-312, 23-5-412, or 23-5-413, MCA.

(h) through (k) remain the same.

AUTH: 23-5-115, 23-5-715, MCA
IMP: 23-5-701, 23-5-702, 23-5-705, 23-5-706, 23-5-710, 23-5-711, MCA

RATIONALE AND JUSTIFICATION: By SB 351, L.1999, the legislature amended 23-5-710, MCA, to, among other things, allow cash and merchandise to be awarded as prizes at casino nights. The administrative rule was not amended to reflect that change, and until recently the conflict remained unnoticed. This rule amendment is therefore reasonable and necessary to harmonize the administrative rule to the law.

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 Rick Ask, Administrator, Gambling Control Division, 2550 Prospect Avenue, P.O. Box 201424, Helena, Montana, 59620-1424; telephone (406) 444-1971; fax (406) 444-9157; or e-mail rask@mt.gov, and must be received no later than 5:00 p.m., August 22, 2013.

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 paragraph 5 above or may be made by completing a request form at any rules hearing held by the department.

7. Cregg W. Coughlin, Assistant Attorney General, Gambling Control Division, has been designated to preside over and conduct the hearing.

8. An electronic copy of this proposal notice is available through the department's web site at https://doj.mt.gov/agooffice/administrative-rules. The department 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 department 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.

9. The bill sponsor contact requirement of 2-4-302, MCA, does apply and has been fulfilled. The primary bill sponsor of HB141 and HB199 [L. 2013] was initially contacted on May 16, 2013 by e-mail and U.S. Postal mail.

10. This rulemaking proceeding was begun prior to July 1, 2013; therefore, the requirements of Chapter 318, Section 1, Laws of 2013, do not apply.

/s/ Tim Fox
TIM FOX
Attorney General, Department of Justice

/s/ Matthew T. Cochenour
MATTHEW T. COCHENOUR
Rule Reviewer

Certified to the Secretary of State July 15, 2013.

BEFORE THE SECRETARY OF STATE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 44.14.304 through 44.14.307 and 44.14.309 pertaining to fees charged by Records and Information Management	)))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On August 15, 2013, at 9:30 a.m., the Secretary of State will hold a public hearing in the Secretary of State's Conference Room, Room 260, State Capitol Building, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The Secretary of State 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 Secretary of State no later than 5:00 p.m. on August 8, 2013, to advise us of the nature of the accommodation that you need. Please contact Jorge Quintana, Secretary of State's Office, P.O. Box 202801, Helena, MT 59620-2801; telephone (406) 461-5173; fax (406) 444-4249; TDD/Montana Relay Service (406) 444-9068; or e-mail jquintana@mt.gov.

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

44.14.304 FEES FOR FILM PROCESSING (1) The following fees will be charged for film processing:

(a) 16mm, each 100 foot roll	$ ~~7.24~~ 7.70
(b) 16mm, each 215 foot roll	~~14.20~~ 14.66
(c) 35mm, each 100 foot roll	~~7.70~~ 8.16

AUTH: ~~2-6-103~~ 2-15-405, MCA
IMP: 2-6-110, MCA

44.14.305 FEES FOR FILM INSPECTING (1) The following fees will be charged for film inspection:

(a) each 100 foot roll inspection	$ 10.64
(b) each 215 foot roll inspection	21.29
(c) each film splice	0.795

AUTH: ~~2-6-103~~ 2-15-405, MCA
IMP: 2-6-110, MCA

44.14.306 FEES FOR FILM DUPLICATION (1) The following fees will be charged for film duplicating:

(a) 16mm, each 100 foot roll	$ 11.76
(b) 16mm, each 215 foot roll	13.03
(c) 35mm, each 100 foot roll	11.80
(d) 105mm, each microfiche or jacket	~~0.379~~ 0.386
(e) each reader/printer copy	0.50
(f) 16mm, 100 foot roll (silver)	~~20.65~~ 21.81
(g) 35mm, 100 foot roll (silver)	~~24.50~~ 25.66

AUTH: ~~2-6-103~~ 2-15-405, MCA
IMP: 2-6-110, MCA

44.14.307 FEES FOR JACKET LOADING/TITLING (1) The following fees will be charged for jacket loading and titling:

(a) 16mm, each 5 channel jacket	$ ~~0.8590~~ 0.879
(b) agency's own jacket (each)	0.2887
(c) 35mm, 1 and 2 channel jacket (each)	~~0.8590~~ 0.879
(d) loading 16mm aperture card (each)	0.8590
(e) jacket title (each)	0.7980
(f) jacket updating (per hour)	24.00

AUTH: ~~2-6-103~~ 2-15-405, MCA
IMP: 2-6-110, MCA

44.14.309 MISCELLANEOUS SUPPLIES (1) The following fees will be charged for filming supplies based on actual cost by supplier:

(a) each NMI reader bulb	$ 11.85
(b) 16mm, each 100 foot roll film	7.10
(c) 35mm, each 100 foot roll film	15.00
(d) each box of splicing tape	~~16.50~~ 17.50
(e) jackets (1 box 16mm/1000)	74.91
(f) fiche envelopes (1 box/1000)	37.50
(g) postage/freight (cost based on actual fee)	Actual

AUTH: ~~2-6-103~~ 2-15-405, MCA
IMP: 2-6-110, MCA

REASON: The increase in fees for these services is reasonably necessary because the charges reflect the fees established in the state term contract for microfilm equipment and supplies (SPB08-1529R) which the Secretary of State is passing on to the state and local agencies that use these services. The additional amount that will be collected through fees associated with document conversion (imaging/microfilming) services will be approximately $446.00 and will affect approximately 18 customers. The authority and implementation statutes were reviewed and updated.

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: Jorge Quintana, Secretary of State's Office, P.O. Box 202801, Helena, Montana 59620-2801; telephone (406) 461-5173; fax (406) 444-4249; or e-mail jquintana@mt.gov, and must be received no later than 5:00 p.m., August 23, 2013.

5. Jorge Quintana, Secretary of State's Office, has been designated to preside over and conduct this hearing.

6. The Secretary of State 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 Secretary of State.

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.

9. With regard to the requirements of Chapter 318, Section 1, Laws of 2013, the Secretary of State has determined that the amendment of the above-referenced rules will not significantly and directly impact small businesses because the fees charged by Records and Information Management only apply to state or local agencies.

/s/ JORGE QUINTANA
Jorge Quintana
Rule Reviewer

/s/ LINDA MCCULLOCH
Linda McCulloch
Secretary of State

Dated this 15th day of July, 2013.

BEFORE THE DEPARTMENT OF COMMERCE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 8.94.3814 pertaining to governing the submission and review of applications for funding under the Treasure State Endowment Program (TSEP)	))))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On June 6, 2013, the Department of Commerce published MAR Notice No. 8-94-116 pertaining to the public hearing on the proposed amendment of the above-stated rule at page 889 of the 2013 Montana Administrative Register, Issue Number 11.

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 comment received and the department's response follows:

COMMENT #1: One comment was received from Becky Beard stating in previous TSEP Administration Manual Guidelines the method of reimbursement takes up to 30 days. Becky Beard stated that she had sent a letter to Commerce, dated October 14, 2011, about this issue. Becky Beard stated that the 30-day turnaround poses a difficulty to grantees with limited financial resources to get payments out to contractors in a timely fashion.

RESPONSE #1: The TSEP Administration Manual for the 2015 Biennium does not reference a number of days for reimbursement. Days allowed to process a request for reimbursement, following receipt of adequate documentation, is described in the contract executed with Commerce and states 15 days.

/s/ G. Martin Tuttle
G. Martin Tuttle
Rule Reviewer

/s/ Meg O'Leary
MEG O'LEARY
Director
Department of Commerce

Certified to the Secretary of State July 15, 2013.

BEFORE THE DEPARTMENT OF COMMERCE
OF THE STATE OF MONTANA

In the matter of the adoption of NEW RULES I through IV pertaining to the implementation of the Montana Indian Language Preservation Pilot Program	))))	NOTICE OF ADOPTION

TO: All Concerned Persons

1. On June 6, 2013, the Department of Commerce published MAR Notice No. 8-99-115 pertaining to the public hearing on the proposed adoption of the above-stated rules at page 891 of the 2013 Montana Administrative Register, Issue Number 11.

2. The department has adopted the above-stated rules as proposed: New Rule I (8.99.1001), New Rule II (8.99.1002), New Rule III (8.99.1003), New Rule IV (8.99.1004).

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

COMMENT #1: A comment was received – in the form of a question to staff – requesting clarification about the acceptable content for audio and visual recordings, whether videotaping experts and speakers, possibly in the form of a theater utilizing the language, or scholarly conferences discussing the language and best practices for passing traditional language on would also be considered under the performance and output standards.

RESPONSE #1: Additional guidance to New Rule I Performance and Output Standards is contained in Section I.G.(1)(h) *Use of Funds* of the Montana Indian Language Preservation Pilot Program Guidelines adopted by the State Tribal Economic Development Commission in that the local program advisory board can determine what respective tribal language preservation activities merit their tribal government's portion of language preservation funding. This section of the guidelines should also be balanced with the consideration that tangible good(s) must be produced or created as a result of the funding and that the legislative intent of the funding is to support the efforts of Montana tribes to preserve Indian languages in the form of spoken, written, or sign language and to assist in the preservation and curricular goals of Indian education for all pursuant to Article X, section 1(2) of the Montana constitution and Title 20, chapter 1, part 5.

COMMENT #2: A comment was received – in the form of a question to staff – if training for teachers and training for other people going into classrooms to teach language would be an eligible activity under language classes (Rule #1 Performance and Output Standards (1)(d)) because language fluency isn't enough to pass on

language skills from one speaker to another. Those who are responsible for teaching language should be able to present their fluency in a classroom in a coherent and understandable manner to students.

RESPONSE #2: Additional guidance to New Rule I Performance and Output Standards is contained in Section I.G.(1)(h) *Use of Funds* of the Montana Indian Language Preservation Pilot Program Guidelines adopted by the State Tribal Economic Development Commission in that the local program advisory board can determine what respective tribal language preservation activities merit their tribal government's portion of language preservation funding. "Train-the-trainer" types of activities required to increase the successful transfer of language skills from teacher to student would be determined at the discretion of the local program advisory board. This section of the guidelines should also be balanced with the consideration that tangible good(s) must be produced or created as a result of the funding and that the legislative intent of the funding is to support the efforts of Montana tribes to preserve Indian languages in the form of spoken, written, or sign language and to assist in the preservation and curricular goals of Indian education for all pursuant to Article X, section 1(2) of the Montana constitution and Title 20, chapter 1, part 5.

COMMENT #3: A comment was received – in the form of a question to staff – of who will own the rights to published literature that result from funding efforts of the Montana Indian Language Preservation Pilot Program.

RESPONSE #3: Additional guidance to this area that falls generally under New Rule IV *Use of Funds* in the Montana Indian Language Preservation Pilot Program and pursuant to Chapter 410, Laws 2013, in that partners determined through the collaboratively developed guidelines that tangible goods produced are done so with public funds and as such should be available for fair use to the public; cultural and intellectual property rights belong to the tribe and may be negotiated between the tribe and partnering entities (Montana Indian Language Preservation Pilot Program Guidelines, Section I. G.(3). Cultural and intellectual property rights are retained by the respective tribal government, but tangible goods produced with public funds must be available for fair use and inspection by the public.

/s/ G. Martin Tuttle
G. Martin Tuttle
Rule Reviewer

/s/ Meg O'Leary
MEG O'LEARY
Director
Department of Commerce

Certified to the Secretary of State July 15, 2013.

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

In the matter of the adoption of a temporary emergency rule closing the Smith River from Camp Baker to Eden Bridge	))))	NOTICE OF ADOPTION OF A TEMPORARY EMERGENCY RULE

TO: All Concerned Persons

1. The Department of Fish, Wildlife and Parks (department) has determined the following reasons justify the adoption of a temporary emergency rule:

(a) Between the dates of July 1 and July 4, 2013, a series of incidents have occurred at multiple boat camps along the lower portion of the river corridor in which one or more black bears have frequented boat camps occupied by floaters.

(b) The incidents have included bears obtaining food from coolers and other containers, a tent and air mattress that were punctured by a bear, and on at least five occasions campers have discharged pepper spray to ward off bears that have no apparent fear of humans.

(c) Persons recreating within this section of the river could be subjected to:

(i) injury due to an encounter with a bear; or

(ii) death caused by a mauling.

(d) Therefore, as this situation constitutes an imminent peril to public health, safety, and welfare, due to the combination of unsafe conditions and this threat cannot be averted or remedied by any other administrative act, the commission adopts the following temporary emergency rule. The emergency rule will be sent as a press release to newspapers throughout the state. Also, signs informing the public of the closure will be posted at access points. The rule will be sent to interested parties, and published as a temporary emergency rule in Issue No. 14 of the 2013 Montana Administrative Register.

2. The commission will make reasonable accommodations for persons with disabilities who wish to participate in the rulemaking process and need an alternative accessible format of the notice. If you require an accommodation, contact the department no later than 5:00 p.m. on August 9, 2013, to advise us of the nature of the accommodation that you need. Please contact Jessica Snyder, Fish, Wildlife and Parks, 1420 East Sixth Avenue, P.O. Box 200701, Helena, MT 59620-0701; telephone (406) 444-9785; fax (406) 444-7456; or e-mail jesssnyder@mt.gov.

3. The temporary emergency rule is effective July 9, 2013 when this rule notice is filed with the Secretary of State.

4. The text of the temporary emergency rule provides as follows:

RULE I SMITH RIVER TEMPORARY EMERGENCY CLOSURE

(1) The closed portion of the Smith River is located in Meagher and Cascade Counties.

(2) The Smith River is closed to all floating on the river between Camp Baker and Eden Bridge.

(3) This rule is effective as long as bears pose a threat to humans.

(4) This rule will expire as soon as the department determines the river is again safe for occupation and recreation. Signs closing the river will be removed when the rule is no longer effective.

AUTH: 2-4-303, 87-1-303, MCA
IMP: 2-4-303, 87-1-303, MCA

5. The rationale for the temporary emergency rule is as set forth in paragraph 1.

6. This rule will expire as soon as the department determines the river is again safe for floating and the rule is repealed. This will depend on the extent and duration of the debris in the area and flow levels. Signs restricting use of the river will be removed when the rule is no longer effective. Notice of repeal of this emergency rule will be published in the Montana Administrative Register.

7. Concerned persons are encouraged to submit their comments to the department. They should submit their comments along with their names and addresses to Jessica Snyder, Legal Unit, Department of Fish, Wildlife and Parks, 1420 East Sixth Avenue, P.O. Box 200701, Helena, MT 59620-0701; telephone (406) 454-5845; fax (406) 444-7456; or e-mail jesssnyder@mt.gov. Any comments must be received no later than August 23, 2013.

8. The Department of Fish, Wildlife and Parks maintains a list of interested persons who wish to receive notice of rulemaking actions proposed by the commission or department. Persons who wish to have their name added to the list shall make written request, which includes the name and mailing address of the person to receive the notice and specifies the subject or subjects about which the person wishes to receive notice. Such written request may be mailed or delivered to Fish, Wildlife and Parks, Legal Unit, P.O. Box 200701, 1420 East Sixth Avenue, Helena, MT 59620-0701, faxed to the office at (406) 444-7456, or may be made by completing the request form at any rules hearing held by the commission or department.

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

/s/ Mike Volesky	/s/ Rebecca Dockter
Mike Volesky, Acting Secretary	Rebecca Dockter
Fish, Wildlife and Parks Commission	Rule Reviewer

Certified to the Secretary of State July 9, 2013.

BEFORE THE FISH AND WILDLIFE COMMISSION
OF THE STATE OF MONTANA

In the matter of the adoption of a temporary emergency rule closing the Clark Fork River from Big Eddy Fishing Access Site to Dry Creek Fishing Access Site in Mineral County	)))))	NOTICE OF ADOPTION OF A TEMPORARY EMERGENCY RULE

TO: All Concerned Persons

1. The Department of Fish, Wildlife and Parks (department) has determined the following reasons justify the adoption of a temporary emergency rule:

(a) The West Mullan wildfire is burning near Superior, Montana.

(b) Fire suppression efforts include several helicopters bucketing water from the Clark Fork River.

(c) The Assistant Fire Management Officer has requested the closure and the department has determined the closure is necessary so helicopter crews can safely operate and maneuver without potential collisions with recreationists on the river. The closure is also necessary so recreationists, including those with limited maneuverability, are not subject to potential collision with large, heavy water buckets suspended from helicopters.

(d) Therefore, as this situation constitutes an imminent peril to public health, safety, and welfare, and this threat cannot be averted or remedied by any other administrative act, the department adopts the following temporary emergency rule. The emergency rule will be sent as a press release to newspapers throughout the state. Also, signs informing the public of the closure will be posted at access points. The rule will be sent to interested parties, and published as a temporary emergency rule in Issue No. 14 of the 2013 Montana Administrative Register.

2. The department will make reasonable accommodations for persons with disabilities who wish to participate in the rulemaking process and need an alternative accessible format of the notice. If you require an accommodation, contact the department no later than 5:00 p.m. on August 9, 2013, to advise us of the nature of the accommodation that you need. Please contact Jessica Snyder, Fish, Wildlife and Parks, 1420 East Sixth Avenue, P.O. Box 200701, Helena, MT 59620-0701; telephone (406) 444-9785; fax (406) 444-7456; or e-mail jesssnyder@mt.gov.

3. The temporary emergency rule is effective July 15, 2013, when this rule notice is filed with the Secretary of State.

4. The text of the temporary emergency rule provides as follows:

RULE I CLARK FORK RIVER TEMPORARY EMERGENCY CLOSURE

(1) A portion of the Clark Fork River is located in Mineral County.

(2) The Clark Fork River is closed from Big Eddy Fishing Access Site to Dry Creek Fishing Access Site to all public occupation and recreation including, but not limited to, floating, swimming, wading, fishing, and boating.

(3) This rule is effective as long as this stretch of river is needed as a source of water for fire suppression efforts.

AUTH: 2-4-303, 87-1-303, MCA
IMP: 2-4-303, 87-1-303, MCA

5. The rationale for the temporary emergency rule is as set forth in paragraph 1.

6. This rule is in effect as long as the stretch of river is needed as a source of water for fire suppression and the department determines the Clark Fork River is again safe for occupation and recreation. This will depend on the extent and duration of the fire in the area. Posted signs regarding the emergency closure will be removed when the rule is no longer effective. Notice of repeal of this emergency rule will be published in the Montana Administrative Register.

7. Concerned persons are encouraged to submit their comments to the department. They should submit their comments along with their names and addresses to Jessica Snyder, Department of Fish, Wildlife and Parks, PO Box 200701, Helena, MT 59620-0701; fax (406) 444-7456; or e-mail jesssnyder@mt.gov. Any comments must be received no later than August 30, 2013.

8. The department maintains a list of interested persons who wish to receive notice of rulemaking actions proposed by the department or commission. Persons who wish to have their name added to the list shall make written request that includes the name and mailing address of the person to receive the notice and specifies the subject or subjects about which the person wishes to receive notice. Such written request may be mailed or delivered to Fish, Wildlife and Parks, Legal Unit, P.O. Box 200701, 1420 East Sixth Avenue, Helena, MT 59620-0701, faxed to the office at (406) 444-7456, or may be made by completing the request form at any rules hearing held by the department.

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

/s/ Mike Volesky
Mike Volesky
Deputy Director
Department of Fish, Wildlife and Parks

/s/ Jack Lynch
Jack Lynch
Rule Reviewer

Certified to the Secretary of State July 15, 2013.

BEFORE THE DEPARTMENT OF CORRECTIONS
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 20.9.701, 20.9.703, 20.9.705, 20.9.706 and 20.9.707 and the repeal of 20.9.702 and 20.9.704 pertaining to the parole and release of youth	)))))	NOTICE OF AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On May 23, 2013, the Department of Corrections published MAR Notice No. 20-9-56 pertaining to the public hearing on the proposed amendment and repeal of the above-stated rules at page 802 of the 2013 Montana Administrative Register, Issue Number 10.

2. The department has amended and repealed the above-stated rules as proposed.

3. No comments or testimony were received.

/s/ Benjamin Reed
Benjamin Reed
Rule Reviewer

/s/ Mike Batista
Mike Batista
Director
Department of Corrections

Certified to the Secretary of State July 15, 2013.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 23.12.401, 23.12.402, 23.12.408, 23.12.430, 23.12.501, 23.12.502, 23.12.601, and 23.12.605 concerning fire safety, fireworks, and Uniform Fire Code; and the repeal of ARM 23.12.420 concerning equipment approval	)))))))	NOTICE OF AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On June 6, 2013, the Department of Justice published MAR Notice No. 23-12-230, pertaining to the proposed amendment and repeal of the above-stated rules at page 897 of the 2013 Montana Administrative Register, Issue Number 11.

2. The department has amended ARM 23.12.401, 23.12.402, 23.12.408, 23.12.430, 23.12.501, 23.12.502, and 23.12.605 as proposed.

3. The department has amended ARM 23.12.601 as proposed, but with the following changes from the original proposal, new matter underlined, deleted matter interlined:

23.12.601 ADOPTION OF THE INTERNATIONAL FIRE CODE (~~2009~~ 2012 EDITION) (1) through (5)(w) remain as proposed.

(x) ~~5706.2.5.1(2)~~ 3406.2.5.1(2) is not adopted.

(y) Appendix B - Fire Flows - is adopted.

(z) Appendix C - Hydrants - is adopted.

(aa) Appendix D - Access Roads: Sections D101-D105.3 - are adopted.

(ab) Appendix I - Fire Protection Systems Non-Compliant Conditions - is adopted.

~~(y) Appendix A - Board of Appeals - is not adopted.~~

~~(z) Appendix D - Access Roads - sections D105.4 through D108 are not adopted.~~

~~(aa) Appendix E - Hazard Categories - is not adopted.~~

~~(ab) Appendix F - Hazard Ranking - is not adopted.~~

~~(ac) Appendix G - Cryogenic Fluids - is not adopted.~~

~~(ad) Appendix H - Hazardous Materials - is not adopted.~~

~~(ae) Appendix J - Building Information Sign - is not adopted.~~

4. 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: A commenter observed that, under section 101.2.1 of the IFC, appendices are not included in the IFC unless they are specifically adopted. The

commenter expressed confusion as to the department's intent in including language that specifically did not adopt appendices and in striking language that specifically adopted certain appendices.

RESPONSE 1: The department agrees with the commenter that the proposed language could lead to confusion and has clarified the rule by deleting the proposed confusing language and by specifically adopting the appendices that are intended to be part of Montana's fire code. The department does not believe that these changes affect the intent or substance of the rule.

5. The department has repealed ARM 23.12.420.

By: /s/ Tim Fox
Tim Fox
Attorney General
Department of Justice

/s/ Matthew T. Cochenour
Matthew T. Cochenour
Rule Reviewer

Certified to the Secretary of State July 15, 2013.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 23.16.1822 and 23.16.1823 pertaining to an increase in video gambling machine permit fees	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On June 6, 2013, the Department of Justice published MAR Notice No. 23-16-231 pertaining to the proposed amendment of the above-stated rules at page 904 of the 2013 Montana Administrative Register, Issue Number 11.

2. The agency has amended ARM 23.16.1822 and 23.16.1823 as proposed.

3. The Gaming Advisory Council members were given an opportunity to review, question, and make suggestions to the proposed rule amendments. No objections, questions, or suggestions were received and a majority of the Council members advised the department to proceed with publication of the rule amendments. No other comments were received.

4. The department intends to apply these rules retroactively to July 1, 2013. A retroactive application of the proposed rules does not result in a negative impact to any affected party.

By: /s/ Tim Fox
TIM FOX
Attorney General
Department of Justice

/s/ Matthew T. Cochenour
MATTHEW T. COCHENOUR
Rule Reviewer

Certified to the Secretary of State July 15, 2013.

BEFORE THE DEPARTMENT OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 32.2.403 pertaining to diagnostic laboratory fees	)))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On June 6, 2013, the Department of Livestock published MAR Notice No. 32-13-231 regarding the proposed amendment of the above-stated rule at page 917 of the 2013 Montana Administrative Register, issue number 11.

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

3. No comments or testimony were received.

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 15, 2013.

BEFORE THE DEPARTMENT OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 32.2.405, 32.18.107, and 32.18.110 and the adoption of NEW RULE I pertaining to Department of Livestock miscellaneous fees, change in brand recording, recording and transferring of brands, and rerecording of brands	))))))))	NOTICE OF AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On June 6, 2013, the Department of Livestock published MAR Notice No. 32-13-233 regarding the proposed amendment and adoption of the above-stated rules at page 927 of the 2013 Montana Administrative Register, issue number 11.

2. The department has amended the above-stated rules exactly as proposed. The department has adopted NEW RULE I (32.18.111) exactly as proposed.

3. No comments or testimony were received.

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 15, 2013.

BEFORE THE DEPARTMENT OF LIVESTOCK
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 32.3.201 and 32.3.212 pertaining to definitions and additional requirements for cattle	))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On May 9, 2013, the Department of Livestock published MAR Notice No. 32-13-234 regarding the proposed amendment of the above-stated rules at page 777 of the 2013 Montana Administrative Register, Issue Number 9.

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

3. No comments or testimony were received.

DEPARTMENT OF LIVESTOCK

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

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

Certified to the Secretary of State July 15, 2013.

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

In the matter of the amendment of ARM 36.12.102, 36.12.103, 36.12.905, 36.12.1301, 36.12.1702, 36.12.1902 and the adoption of New Rule I regarding water right permitting	)))))	NOTICE OF AMENDMENT AND ADOPTION

To: All Concerned Persons

1. On June 6, 2013, the Department of Natural Resources and Conservation published MAR Notice No. 36-22-174 regarding a notice of public hearing on the proposed amendment and adoption of the above-stated rules at page 931 of the 2013 Montana Administrative Register, Issue No. 11.

2. The department has amended ARM 36.12.905, 36.12.1301, 36.12.1702, and 36.12.1902 as proposed.

3. The department has amended ARM 36.12.102 and 36.12.103 as proposed, but with the following changes from the original proposal, new matter underlined, deleted matter interlined:

36.12.102 FORMS

(1) through (1)(ai) remain as proposed.

(aj) Form No. 652, "Petition for ~~Net~~ Stream Depletion Zone." ~~.~~

36.12.103 FORM AND SPECIAL FEES

(1) through (2)(aa) remain as proposed.

(ab) $750 for Form No. 652, Petition for ~~Net~~ Stream Depletion Zone.

(3) and (4) remain as proposed.

4. The department has adopted New Rule I (36.12.2101) as proposed, but with the following changes from the original proposal, new matter underlined, deleted matter interlined:

NEW RULE I (36.12.2101) TEMPORARY LEASE OF APPROPRIATION RIGHT (1) An appropriator wishing to temporarily lease a water right pursuant to 85-2-427, MCA, must file an application to temporarily lease an appropriation right (Form 650). An application may only be filed by the owner of the water right as recorded in the department's water rights records.

(2) and (3) remain as proposed.

(4) The department will use the following standards for consumptive use when reviewing applications for temporary leases:

(a) for irrigation, consumptive ~~use is~~ volume may not exceed 1.0 acre-foot per acre irrigated as defined in 85-2-427(2), MCA;

(b) through (6) remain as proposed.

5. The department has thoroughly considered the comments received. A summary of the comments received and the department's responses follow:

COMMENT 1:
Commenter stated that New Rule I Temporary Lease of Appropriation Right needs to clarify that "the two out of every ten years provision" (ARM 36.12.2101(2)) only applies to temporary leases under HB 37 (Chapter 236, 2013 Laws of Montana), not instream flow leases under 85-2-408, MCA.

RESPONSE 1:
The department intends that the rule only implement 85-2-427, MCA, as noted in the cited implementation statute. In order to clarify the entire rule, the department has amended New Rule I(1) (ARM 36.12.2101(1)) to read: "An appropriator wishing to temporarily lease a water right pursuant to 85-2-427, MCA, must file an application to temporarily lease an appropriation right (Form 650). An application may only be filed by the owner of the water right as recorded in the department's water rights records."

COMMENT 2:
Commenter provided general suggestions for the content and use of proposed form "Petition for Net Depletion Zone."

RESPONSE 2:
85-2-112(2), MCA, authorizes the department to develop forms consistent with the requirements of Title 85, chapter 2, MCA. Pursuant to this authority, the department will develop an appropriate Form No. 652 setting forth the information required by the department to initiate rulemaking to establish a stream depletion zone consistent with SB 346.

COMMENT 3:
Commenter was concerned that SB 346 (Chapter 421, 2013 Laws of Montana) does not use the term "Net Depletion Zone," and that the proposed title for Form 652 in ARM 36.12.102(1)(aj) and 36.12.103(2)(ab) was inaccurate.

RESPONSE 3:
The department agrees and has amended the title of Form 652 in ARM 36.12.102(1)(aj) and 36.12.103(2)(ab) to "Petition for ~~Net~~ Stream Depletion Zone."

DEPARTMENT COMMENT:
85-2-427(2), MCA, provides: "For an irrigation right, the consumptive volume may not exceed 1 acre-foot per acre irrigated." The department has determined the language and citation to 85-2-427, MCA, in New Rule I(4)(a) was deficient and conflicted with the statutory section implemented by the rule. The department has amended New Rule I (ARM 36.12.2101(4)(a)) to correct the language and citation to conform with the statute.

DEPARTMENT OF NATURAL RESOURCES AND CONSERVATION

/s/ John E. Tubbs
JOHN E. TUBBS
Director
Natural Resources and Conservation

/s/ Brian Bramblett
BRIAN BRAMBLETT
Rule Reviewer

Certified to the Secretary July 15, 2013.

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

In the matter of the amendment of ARM 37.34.901 and the repeal of ARM 37.34.902, 37.34.906, 37.34.907, 37.34.911, 37.34.912, 37.34.913, 37.34.917, 37.34.918, 37.34.919, 37.34.925, 37.34.926, 37.34.929, 37.34.930, 37.34.933, 37.34.934, 37.34.937, 37.34.938, 37.34.941, 37.34.942, 37.34.946, 37.34.947, 37.34.950, 37.34.951, 37.34.954, 37.34.955, 37.34.956, 37.34.957, 37.34.960, 37.34.961, 37.34.962, 37.34.963, 37.34.967, 37.34.968, 37.34.971, 37.34.972, 37.34.973, 37.34.974, 37.34.978, 37.34.979, 37.34.980, 37.34.981, 37.34.985, 37.34.986, 37.34.987, and 37.34.988 pertaining to Medicaid home and community-based service program for individuals with developmental disabilities	)	NOTICE OF DECISION ON PROPOSED RULE ACTIONS

TO: All Concerned Persons

1. On April 25, 2013, the Department of Public Health and Human Services published MAR Notice No. 37-631 pertaining to the public hearing on the proposed amendment and repeal of the above-stated rules at page 593 of the 2013 Montana Administrative Register, Issue Number 8.

2. A public hearing on the notice of proposed amendment and repeal of the above-stated rules was held on May 16, 2013.

3. Due to the extent of the changes required by the Center for Medicaid and Medicare Services to the 1915(c) Developmental Disability 0208 Home and Community-Based waiver application, the department determined it would be prudent to withdraw this proposed notice.

/s/ Cary B. Lund
Cary B. Lund
Rule Reviewer

/s/ Richard H. Opper
Richard H. Opper, Director
Public Health and Human Services

Certified to the Secretary of State July 15, 2013.

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, 2013. This table includes those rules adopted during the period April 1, 2013, through June 30, 2013, and any proposed rule action that was pending during the past 6-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, 2013, 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 2013 Montana Administrative Register.

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BOARD APPOINTEES AND VACANCIES

Section 2-15-108, MCA, passed by the 1991 Legislature, directed that all appointing authorities of all appointive boards, commissions, committees, and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of 2-15-108, MCA, is that the Secretary of State publish monthly in the ***Montana Administrative Register*** a list of appointees and upcoming or current vacancies on those boards and councils.

In this issue, appointments effective in June 2013 appear. Vacancies scheduled to appear from August 1, 2013, through October 31, 2013, are listed, as are current vacancies due to resignations or other reasons. Individuals interested in serving on a board should refer to the bill that created the board for details about the number of members to be appointed and necessary qualifications.

Each month, the previous month's appointees are printed, and current and upcoming vacancies for the next three months are published.

IMPORTANT

Membership on boards and commissions changes constantly. The following lists are current as of July 1, 2013.

For the most up-to-date information of the status of membership, or for more detailed information on the qualifications and requirements to serve on a board, contact the appointing authority.

BOARD AND COUNCIL APPOINTEES FROM JUNE 2013

Appointee	Appointed by	Succeeds	Appointment/End Date
Director of the Office of Community Affairs (Governor)			
Mr. Dan Ritter	Governor	not listed	6/24/2013
Helena			0/0/0
Qualifications (if required): none specified			
District Court Judge District 16 (Justice)			
Judge Michael Hayworth	Governor	Day	6/19/2013
Forsyth			1/1/2015
Qualifications (if required): appointed			
Fish, Wildlife and Parks Commission (Fish, Wildlife and Parks)			
Mr. Gary Wolfe	Governor	Ream	6/14/2013
Missoula			1/1/2017
Qualifications (if required): District 1			
Montana Health Coalition (Public Health and Human Services)			
Rep. Edith J. Clark	Director	not listed	6/7/2013
Sweet Grass			6/7/2015
Qualifications (if required): none specified			
Ms. Mary Dalton	Director	not listed	6/7/2013
Helena			6/7/2015
Qualifications (if required): none specified			
Dr. Steve Helgerson	Director	not listed	6/7/2013
Helena			6/7/2015
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM JUNE 2013

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Health Coalition (Public Health and Human Services) cont.			
Mr. Travis Hoffman	Director	not listed	6/7/2013
Missoula			6/7/2015
Qualifications (if required): none specified			
Mr. S. Kevin Howlett	Director	not listed	6/7/2013
Arlee			6/7/2015
Qualifications (if required): none specified			
Ms. Leigh Ann Logan	Director	not listed	6/7/2013
Billings			6/7/2015
Qualifications (if required): none specified			
Mr. Bob Marsalli	Director	not listed	6/7/2013
Helena			6/7/2015
Qualifications (if required): none specified			
Dr. Gary Mihelish	Director	not listed	6/7/2013
Helena			6/7/2015
Qualifications (if required): none specified			
Mr. Shane Roberts	Director	not listed	6/7/2013
Ronan			6/7/2015
Qualifications (if required): none specified			
Mr. Eric Shields	Director	not listed	6/7/2013
Missoula			6/7/2015
Qualifications (if required): none specified			

BOARD AND COUNCIL APPOINTEES FROM JUNE 2013

Appointee	Appointed by	Succeeds	Appointment/End Date
Montana Health Coalition (Public Health and Human Services) cont.			
Ms. Jane Smilie	Director	not listed	6/7/2013
PO Box 202951			6/7/2015
Qualifications (if required): none specified			
Ms. Kristianne Wilson	Director	not listed	6/7/2013
Billings			6/7/2015
Qualifications (if required): none specified			
Tourism Advisory Council (Governor)			
Ms. Stacey Kiehn	Governor	DesRosier	6/14/2013
Charlo			7/1/2014
Qualifications (if required): Glacier Country Tourism Region			

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Alternative Health Care Board (Labor and Industry)		
Ms. Molly Danison, Missoula Qualifications (if required): midwife	Governor	9/1/2013
Board of Athletic Trainers (Labor and Industry)		
Mr. Bob Fletcher, Bozeman Qualifications (if required): public representative	Governor	10/1/2013
Mr. Shawn Ruff, Great Falls Qualifications (if required): public representative	Governor	10/1/2013
Board of Barbers and Cosmetologists (Labor and Industry)		
Mr. Wendell Petersen, Missoula Qualifications (if required): cosmetologist	Governor	10/1/2013
Ms. Jamie Ausk Crisafulli, Glendive Qualifications (if required): public representative	Governor	10/1/2013
Mr. William Graves, Great Falls Qualifications (if required): barber	Governor	10/1/2013
Ms. Sherry Dembowski-Wieckowski, Thompson Falls Qualifications (if required): barber	Governor	10/1/2013
Board of Medical Examiners (Labor and Industry)		
Ms. Carole Erickson, Missoula Qualifications (if required): public representative	Governor	9/1/2013

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Board of Medical Examiners (Labor and Industry) cont.		
Mr. Dwight Thompson, Harlowton	Governor	9/1/2013
Qualifications (if required): licensed physician assistance		
Dr. Kris Spanjian, Billings	Governor	9/1/2013
Qualifications (if required): doctor of medicine		
Ms. Patricia Bollinger, Helena	Governor	9/1/2013
Qualifications (if required): nutritionist		
Ms. Linda Cetrone Levy, Billings	Governor	9/1/2013
Qualifications (if required): public representative		
Mr. Ryan Burke, Great Falls	Governor	9/1/2013
Qualifications (if required): volunteer emergency medical technician		
Ms. Eileen Sheehy, Billings	Governor	9/1/2013
Qualifications (if required): public representative		
Mr. Charles Farmer, Cut Bank	Governor	9/1/2013
Qualifications (if required): volunteer emergency medical technician		
Mrs Ana Diaz, Billings	Governor	9/1/2013
Qualifications (if required): Public Representative		

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Board of Outfitters (Labor and Industry)		
Mr. John Wilkinson, Miles City	Governor	10/1/2013
Qualifications (if required): fishing and hunting outfitter		
Board of Private Security (Labor and Industry)		
Mr. Mark Chaput, Billings	Governor	8/1/2013
Qualifications (if required): representative of an electronic security company		
Board of Psychologists (Labor and Industry)		
Dr. Susan Mattocks, Miles City	Governor	9/1/2013
Qualifications (if required): private practice psychologist		
Board of Veterans' Affairs (Military Affairs)		
General John Walsh, Helena	Governor	8/1/2013
Qualifications (if required): Adjutant General		
Mr. Keith Heavyrunner, Browning	Governor	8/1/2013
Qualifications (if required): veteran and resident of Region 3		
Ms. Jennifer Perez Cole, Helena	Governor	8/1/2013
Qualifications (if required): director of the Office of Indian Affairs		
Mr. Byron Erickson, Helena	Governor	8/1/2013
Qualifications (if required): U.S. Department of Labor Representative		
Burial Preservation Board (Administration)		
Mr. Robert P. Four Star, Poplar	Governor	8/22/2013
Qualifications (if required): representative of the Fort Peck Tribes		

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Burial Preservation Board (Administration) cont.		
Mr. Steve Platt, Helena	Governor	8/22/2013
Qualifications (if required): representative of the State Historic Preservation Office		
Mr. John Murray, Browning	Governor	8/22/2013
Qualifications (if required): representative of the Blackfeet Tribe		
Mr. Reuben Mathias, Pablo	Governor	8/22/2013
Qualifications (if required): representative of the Salish-Kootenai Tribes (Flathead)		
Ms. Marilyn Silva, Miles City	Governor	8/22/2013
Qualifications (if required): public representative		
Ms. Skye Gilham, Browning	Governor	8/22/2013
Qualifications (if required): physical anthropologist		
Claims Data Analysis Council (State Auditor)		
Rep. Chuck Hunter, Helena	State Auditor	10/13/2013
Qualifications (if required): none specified		
Rep. Monica J. Lindeen, Huntley	State Auditor	10/13/2013
Qualifications (if required): none specified		
Ms. Claudia Clifford, Helena	State Auditor	10/13/2013
Qualifications (if required): none specified		
Ms. Tanya Ask, Helena	State Auditor	10/13/2013
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Claims Data Analysis Council (State Auditor) cont.		
Mr. Gregg Davis, Missoula Qualifications (if required): none specified	State Auditor	10/13/2013
Mr. Don Creveling, Missoula Qualifications (if required): none specified	State Auditor	10/13/2013
Mr. Barnard Khomenko, Missoula Qualifications (if required): none specified	State Auditor	10/13/2013
Mr. Frank Cote, Helena Qualifications (if required): none specified	State Auditor	10/13/2013
Mr. Robert Shepard, Clancy Qualifications (if required): none specified	State Auditor	10/13/2013
Mr. Jon Bennion, Helena Qualifications (if required): none specified	State Auditor	10/13/2013
Dr. Tom Roberts, Missoula Qualifications (if required): none specified	State Auditor	10/13/2013
Dr. William Reiter, Anaconda Qualifications (if required): none specified	State Auditor	10/13/2013
Mr. Joseph Lotus, Chicago Qualifications (if required): none specified	State Auditor	10/13/2013

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Claims Data Analysis Council (State Auditor) cont.		
Ms. Megan O'Halloran, Milwaukee Qualifications (if required): none specified	State Auditor	10/13/2013
Ms. Roberta Yager, Helena Qualifications (if required): none specified	State Auditor	10/13/2013
Ms. Jan Hoy, Billings Qualifications (if required): none specified	State Auditor	10/13/2013
Ms. Rebecca Kelly, Billings Qualifications (if required): none specified	State Auditor	10/13/2013
Mr. Dror Baruch, Billings Qualifications (if required): none specified	State Auditor	10/13/2013
Mr. Alan Hall, Missoula Qualifications (if required): none specified	State Auditor	10/13/2013
Flathead Basin Commission (Natural Resources and Conservation)		
Ms. Jan Metzmaker, Whitefish Qualifications (if required): public representative	Governor	10/1/2013
Ms. Margaret Sogard, Bigfork Qualifications (if required): public representative	Governor	10/1/2013

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Flathead Basin Commission (Natural Resources and Conservation)		
Mr. Thompson R. Smith, Charlo Qualifications (if required): public representative	Governor	10/1/2013
Mr. Chas Cartwright, Columbia Falls Qualifications (if required): Public Representative	Governor	10/1/2013
Historical Preservation Review Board (Historical Society)		
Mr. Donald Matlock, Hamilton Qualifications (if required): public representative	Governor	10/1/2013
Historical Records Advisory Council (Historical Society)		
Ms. Ellen Crain, Butte Qualifications (if required): public representative	Governor	10/12/2013
Mr. Kim Allen Scott, Bozeman Qualifications (if required): public representative	Governor	10/12/2013
Ms. Judy Ellinghausen, Great Falls Qualifications (if required): public representative	Governor	10/12/2013
Ms. Anne L. Foster, Huntley Qualifications (if required): public representative	Governor	10/12/2013
Ms. Jodie Foley, Helena Qualifications (if required): state archivist	Governor	10/12/2013

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Historical Records Advisory Council (Historical Society) cont.		
Mr. Jon Ille, Hardin Qualifications (if required): public representative	Governor	10/12/2013
Mr. Samuel Meister, Missoula Qualifications (if required): public representative	Governor	10/12/2013
Medical Home Working Group (State Auditor)		
Mr. John Hoffland, Helena Qualifications (if required): none specified	State Auditor	8/21/2013
Dr. Deborah Agnew, Billings Qualifications (if required): none specified	State Auditor	8/21/2013
Ms. Paula Block, Helena Qualifications (if required): none specified	State Auditor	8/21/2013
Dr. Doug Carr, Billings Qualifications (if required): none specified	State Auditor	8/21/2013
Dr. Paul Cook, Billings Qualifications (if required): none specified	State Auditor	8/21/2013
Dr. Janice Gomersall, Missoula Qualifications (if required): none specified	State Auditor	8/21/2013

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Medical Home Working Group (State Auditor) cont.		
Dr. Jonathan Griffin, Helena Qualifications (if required): none specified	State Auditor	8/21/2013
Ms. Kristin Juliar, Bozeman Qualifications (if required): none specified	State Auditor	8/21/2013
Ms. Carol Kelley, Bozeman Qualifications (if required): none specified	State Auditor	8/21/2013
Mr. Jay Larson, Helena Qualifications (if required): none specified	State Auditor	8/21/2013
Ms. Kirsten Mailloux, Billings Qualifications (if required): none specified	State Auditor	8/21/2013
Mr. Bob Olson, Helena Qualifications (if required): none specified	State Auditor	8/21/2013
Dr. Fred Olson, Helena Qualifications (if required): none specified	State Auditor	8/21/2013
Mr. Bill Pfingsten, Bozeman Qualifications (if required): none specified	State Auditor	8/21/2013
Dr. Tom Roberts, Missoula Qualifications (if required): none specified	State Auditor	8/21/2013

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Medical Home Working Group (State Auditor) cont.		
Ms. Bernadette Roy, Missoula Qualifications (if required): none specified	State Auditor	8/21/2013
Dr. Rob Stenger, Great Falls Qualifications (if required): none specified	State Auditor	8/21/2013
Ms. Claudia Stephens, Billings Qualifications (if required): none specified	State Auditor	8/21/2013
Ms. Lisa Wilson, Missoula Qualifications (if required): none specified	State Auditor	8/21/2013
Mr. Rick Yearry, Helena Qualifications (if required): none specified	State Auditor	8/21/2013
Montana Noxious Weed Seed Free Forage Advisory Council (Agriculture)		
Mr. James Bouma, Choteau Qualifications (if required): forage producer	Director	9/17/2013
Mr. Kehoe Wayman, Ronan Qualifications (if required): representative of the outfitters and guides	Director	9/17/2013
Mr. Mark Siderius, Kalispell Qualifications (if required): forage producer	Director	9/17/2013

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Montana Wheat and Barley Committee (Agriculture)		
Mr. Chris Kolstad, Ledger	Governor	8/20/2013
Qualifications (if required): wheat and/or barley producer in District 3		
Mr. Randy Hinebauch, Conrad	Governor	8/20/2013
Qualifications (if required): wheat and/or barley producer in District 2		
Poet Laureate (Montana Arts Council)		
Ms. Sheryl Noethe, Missoula	Governor	8/1/2013
Qualifications (if required): Montana poet		
Statewide Interoperability Governing Board (Administration)		
Mr. Tim Reardon, Helena	Governor	9/30/2013
Qualifications (if required): Director of the Montana Department of Transportation		
Mr. Dick Clark, Helena	Governor	9/30/2013
Qualifications (if required): Chief Information Officer		
Sheriff Leo C. Dutton, Helena	Governor	9/30/2013
Qualifications (if required): representative of the Montana's Sheriffs and Peace Officers Association		
Ms. Sheena Wilson, Helena	Governor	9/30/2013
Qualifications (if required): Governor's office representative		
Atty General Steve Bullock, Helena	Governor	9/30/2013
Qualifications (if required): Attorney General		

VACANCIES ON BOARDS AND COUNCILS -- AUGUST 1, 2013 THROUGH OCTOBER 31, 2013

Board/current position holder	Appointed by	Term end
Vocational Rehabilitation Council (Public Health and Human Services)		
Mr. Bob Maffit, Helena	Governor	10/1/2013
Qualifications (if required): statewide independent living council representative		
Ms. Nina Cramer, Missoula	Governor	10/1/2013
Qualifications (if required): representative of organized labor		
Ms. Mary Hall, Missoula	Governor	10/1/2013
Qualifications (if required): parent organization representative		
Ms. Chanda Hermanson, Helena	Governor	10/1/2013
Qualifications (if required): advocacy program representative		
Ms. Nikki Sandve, Helena	Governor	10/1/2013
Qualifications (if required): state education agency representative		
Ms. Kate Gangner, Great Falls	Governor	10/1/2013
Qualifications (if required): community rehabilitation program representative		
Ms. Marla Swanby, Helena	Governor	10/1/2013
Qualifications (if required): State education agency representative		
Water and Waste Water Operators' Advisory Council (Environmental Quality)		
Mr. Donald Coffman, Harlem	Governor	10/16/2013
Qualifications (if required): water treatment plant operator		