MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 13

The Montana Administrative Register (MAR), a twice-monthly publication, has three sections. The Notice Section contains state agencies' proposed new, amended, or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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 Section contains final rule notices which show any changes made since the proposal stage. All rule actions are effective the day after 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 Administrative Rules Bureau at (406) 444-2055.

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BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the adoption of new Rules I through X regarding definitions, licensing and application requirements, ownership change, examination of title lenders, duration of loans, extensions, reports, schedule of charges, employees' character and fitness, and procedural rules for hearing and discovery proposed for adoption under the Montana Title Loan Act	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION

TO: All Concerned Persons

1. On August 17, 2005, at 10:00 a.m., a public hearing will be held in Room 342 of the Park Avenue Building, 301 S. Park, Helena, Montana, to consider the adoption of new Rules I through X.

2. The Department of Administration, Division of Banking and Financial Institutions, 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 Division of Banking and Financial Institutions no later than 5:00 p.m. on August 12, 2005, to advise us of the nature of the accommodation that you need. Please contact Christopher Romano, Division of Banking and Financial Institutions, P.O. Box 200546, Helena, Montana 59620-0546; telephone (406) 841-2928; TDD (406) 444-1421; facsimile (406) 841-2930; e-mail to cromano@mt.gov.

3. The proposed new rules provide as follows:

RULE I DEFINITIONS For the purposes of the Montana Title Loan Act and this subchapter, the following definitions apply:

(1) "Commissioner" means the commissioner of banking and financial institutions provided for in 32-1-211, MCA.

(2) "Day" means 24-hour period of time.

(3) "Department" means the department of administration established in 2-15-1001, MCA, and includes the commissioner of the division of banking and financial institutions.

(4) "Extension" means an agreement whereby the licensee agrees to extend the due date beyond the term of the original title loan without releasing the security interest on the titled property.

(5) "Original title loan" means the title loan agreement which is the basis for taking possession of the title and perfecting security interest on titled property.

(6) "Redemption date" is the maturity date of the original title loan and any subsequent renewals or extensions.

(7) "Redemption period" means 20 days after licensee has provided notice of default plus three days for mailing.

(8) "Renewal" means extension.

AUTH: 31-1-802, MCA
IMP: 31-1-804, 31-1-810, 31-1-812, MCA

RULE II LICENSING AND APPLICATION REQUIREMENTS - EXCEPTIONS (1) Except for those entities listed in (2), all persons or lenders must obtain a license under this rule in order to issue title loans. Persons or lenders that are licensed under the Consumer Loan Act, 32-5-101, MCA, and Deferred Deposit Loan Act, 31-1-701, MCA, are not exempt from the licensing requirements of 31-1-801, MCA.

(2) The following are exempt from the licensing requirements:

(a) federal and state chartered banks;

(b) federal and state chartered savings and loans;

(c) federal and state credit unions;

(d) trust companies; and

(e) investment companies.

(3) All existing or proposed licensees shall file with the department an application in order to engage in title lending.

(4) An application must be in writing on a form prescribed by the department and verified under oath. Application forms are available from the Division of Banking and Financial Institutions, Department of Administration, 301 S. Park, P.O. Box 200546, Helena, MT 59620-0546.

(5) In addition to any other information that may be required by 31-1-805, MCA, the application shall contain the following information in the application format prescribed by the department:

(a) biographical data concerning the applicant, the applicant's owners, parent company, affiliates, or subsidiaries as specified by the department;

(b) information concerning the applicant's character, experience, qualifications; and

(c) financial information about the applicant.

AUTH: 31-1-802, MCA
IMP: 31-1-804, 31-1-805, 31-1-811, MCA

RULE III OWNERSHIP CHANGE (1) In the event there is a change of ownership in a licensee, the owner(s) shall file with the department an application for a new license. For purposes of this rule, a change in ownership includes circumstances when 25% or more of the ownership is transferred to a new owner.

AUTH: 31-1-802, MCA
IMP: 31-1-805, MCA

<u>RULE IV EXAMINATION OF TITLE LENDERS</u> (1) The department shall annually conduct an examination of each title loan licensee's lending operations to ensure compliance with both statute and administrative rule.

(2) The examination shall consist of a comprehensive review of the records, operations and affairs of the licensee. The review shall include inquiry into:

(a) accounting and financial records;

(b) records of the borrower's files including:

(i) evidence of required disclosures;

(ii) use of the department approved loan agreement; and

(iii) assurance of continued bonding.

AUTH: 31-1-802, MCA
IMP: 31-1-810, MCA

<u>RULE V DURATION OF LOANS - INTEREST - EXTENSIONS</u>

(1) Each original title loan must have a term of 30 days. No interest or fees may be charged beyond the 30-day period without a bona fide extension of the loan in accordance with (2).

(2) Automatic extensions or renewals are prohibited. Each extension or renewal must be specifically agreed upon in writing by the borrower at the time the extension is granted.

(3) Except as provided in [New Rule VI] for reduction of principal, each agreed upon extension must have a term of 30 days and must contain:

(a) total principal amount financed;

(b) total finance charges;

(c) total amount financed;

(d) new annual percentage rate calculations;

(e) new maturity date;

(f) new collateral redemption date;

(g) payment of accrued interest from previous loan; and

(h) signature of the borrower;

(4) A licensee shall not exceed any additional credit than that which was granted in the original title loan agreement without first requiring full payment of all principal and interest due on the original title loan, or any subsequent extensions, and release the security interest in the titled property.

(5) Licensees may not issue a new original loan to pay off the previous original loan.

AUTH: 31-1-802, MCA
IMP: 31-1-816, MCA

<u>RULE VI EXTENSIONS - REDUCTION OF PRINCIPAL</u>

(1) Subject to (2), beginning with the sixth extension and for each subsequent extension, the borrower must pay at least 10% of the original principal amount along with all accrued interest before an extension may be granted.

(2) In the event that a borrower fails to reduce the principal and interest as required in (1), a licensee at its option may either:

(a) declare the full outstanding principal and interest due and payable; or

(b) reduce the amount of principal balance used to calculate interest by 10% every 30 days beginning 180 days from the beginning of the original title loan agreement. In such event, the licensee must comply with all the requirements of [New Rule V] for extensions.

(3) Under no circumstances may a licensee charge interest or fees beyond the fifteenth extension.

AUTH: 31-1-802, MCA
IMP: 31-1-816, MCA

RULE VII REPORTS (1) The following must be reported to the department:

(a) any instances of theft or missing funds within 10 days of each occurrence;

(b) any change in managers within 10 days of each occurrence; and

(c) all officer questionnaires must be answered within 10 days of the end of any examination.

AUTH: 31-1-802, MCA
IMP: 31-1-815, MCA

RULE VIII SCHEDULE OF CHARGES (1) Every licensee under the Montana Title Loan Act shall file with the commissioner in duplicate, at the time of filing application for such license or license renewal, a full and accurate schedule of all charges, fees and costs as follows:

(a) interest rate;

(b) non-sufficient fund fees;

(c) lien recording and release fees;

(d) examples of typical loan amounts including principal, interest and fees; and

(e) a statement that storage fees and repossession fees shall be added to amount due based upon actual cost of these services to the licensee.

(2) Licensees shall display such schedule prominently in each licensed place of business where loans are made or negotiated so as to be easily readable by borrowers and prospective borrowers.

AUTH: 31-1-802, MCA
IMP: 31-1-816, 31-1-817, 31-4-818, MCA

RULE IX EMPLOYEES' CHARACTER AND FITNESS (1) Licensees are responsible for conducting appropriate background checks on all applicants for employment. At a minimum, each licensee shall:

(a) require completion of employee criminal background questionnaire;
(b) verify and document employment and personal references; and
(c) within 10 days of start of employment, request a Montana criminal records check from the department of justice.
(2) If the background check demonstrates any criminal convictions involving fraud or financial dishonesty or civil judgments involving fraudulent or dishonest financial dealings, the licensee cannot employ such person, or if already employed, must terminate employment.
(3) Verification of compliance with this rule shall occur during annual exams. Licensees are required to keep accurate employment records on each employee to ensure that the department is able to verify compliance.

AUTH: 31-1-802, MCA
IMP: 31-1-805, MCA

RULE X PROCEDURAL RULES FOR HEARINGS AND DISCOVERY
(1) In the case of hearings concerning the issuance, suspension, revocation, or other enforcement actions pertaining to a licensee, hearings and related discovery shall be done under the Montana Administrative Procedure Act implementing the revised attorney general's model rules effective June 4, 1999.
(2) The department of administration, division of banking and financial institutions, adopts and incorporates by reference the attorney general's model rules effective June 4, 1999 as found in ARM 1.3.101 through 1.3.233, along with the accompanying forms. A copy of the attorney general's rules may be obtained from the Division of Banking and Financial Institutions, Department of Administration, 301 S. Park, P.O. Box 200546, Helena, MT 59620-0546.

AUTH: 31-1-802, MCA
IMP: 31-1-811, 31-1-812, MCA

REASON: The 2001 Montana Legislature enacted House Bill 539, which was an Act creating the Montana Title Loan Act. This Act has been codified in Title 32, Chapter 1, part 8, MCA. Section 31-1-802, MCA requires the Department to adopt rules to implement the provisions of the Act. New rules I through X are being proposed to fulfill this general legislative mandate and to address the specific rulemaking mandates of Section 31-1-802(2), MCA. The Department does not anticipate any financial impact from the proposed rules. There are currently 43 title loan licensees.

4. Concerned persons may present their data, views or arguments, either orally or in writing, at the hearing. Written data, views or arguments may also be submitted to Mark Prichard, Legal Counsel, Division of Banking and Financial Institutions, P.O. Box 200546, Helena, Montana 59620-0546;

faxed to the office at (406) 841-2930; e-mailed to mprichard@mt.gov, and must be received no later than August 12, 2005.

5. Mark Prichard, Legal Counsel, Division of Banking and Financial Institutions, has been designated to preside over and conduct the hearing.

6. An electronic copy of this Notice of Public Hearing on Proposed Adoption is available through the Department's website on the World Wide Web at http://www.discoveringmontana.com/doa, under "public meetings/notices;" and "administrative rule notices." The department strives to make the electronic copy of this Notice conform to the official version of the Notice as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the Department strives to keep its website accessible at all times, concerned persons should be aware that the website may be unavailable during some periods, due to system maintenance or technical problems and that a person's technical difficulties in accessing or posting to the e-mail address do not excuse late submission or comments.

7. The Division of Banking and Financial Institutions maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this division. Persons who wish to have their name added to the mailing list shall make a written request which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding division rulemaking actions. Such written requests may be mailed or delivered to Christopher Romano, Division of Banking and Financial Institutions, 301 S. Park, Suite 316, P.O. Box 200546, Helena, Montana 59620-0546; faxed to the office at (406) 841-2930; emailed to cromano@mt.gov, or may be made by completing a request form at any rules hearing held by the Division of Banking and Financial Institutions.

8. The bill sponsor notice requirements of 2-4-302, MCA, apply and have been fulfilled.

By: /s/ Janet R. Kelly
Janet R. Kelly, Director
Department of Administration

By: /s/ Dal Smilie
Dal Smilie, Rule Reviewer
Department of Administration

Certified to the Secretary of State July 1, 2005.

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

In the matter of the proposed amendment of ARM 6.6.504, 6.6.505, 6.6.506, 6.6.507, 6.6.507A, 6.6.507B, 6.6.507C, 6.6.508, 6.6.508A, 6.6.509, 6.6.510, 6.6.511, 6.6.519, 6.6.520, 6.6.521, 6.6.608, 6.6.612, and 6.6.613, and the adoption of new rules I through III pertaining to medicare supplements	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On August 8, 2005, at 10:00 a.m., a public hearing will be held in the 2nd floor conference room, State Auditor's Office, 840 Helena Avenue, Helena, Montana, to consider the proposed amendment and adoption of the above-stated rules, pertaining to medicare supplements.

2. The State Auditor's Office 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 office no later than 5:00 p.m., July 29, 2005, to advise us of the nature of the accommodation that you need. Please contact Darla Sautter, State Auditor's Office, 840 Helena Avenue, Helena, MT 59601; telephone (406) 444-2726; Montana Relay 1-800-332-6145; TDD (406) 444-3246; facsimile (406) 444-3497; or e-mail to dsautter@mt.gov.

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

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

(1) "Bankruptcy" means when a ~~medicare+choice~~ medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(2) through (5)(c) remain the same.

(6) "Creditable coverage" ~~shall~~ may not include the following benefits if offered as independent, noncoordinated benefits:

(a) and (b) remain the same.

~~(7) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:~~

~~(a) medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act and also medicare select;~~

~~(b) coverage supplemental to the coverage provided under chapter 55 of Title 10USC; and~~

~~(c) similar supplemental coverage provided to coverage under a group health plan.~~

(8) and (9) remain the same, but are renumbered (7) and (8).

~~(10)~~(9) "~~Medicare+choice~~ medicare advantage plan" means a plan of coverage for health benefits under medicare part C as defined in 42 USC 1395w-28(b)(1), and includes:

(a) remains the same.

(b) medical savings account plans coupled with a contribution into a ~~medicare+choice~~ medicare advantage plan medical savings account; and

(c) ~~medicare+choice~~ medicare advantage private fee-for-service plans.

(10) "Medicare supplement policy" has the meaning provided for in 33-22-903, MCA, except that "medicare supplement policy" does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D, or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act.

(11) remains the same.

AUTH: 33-1-313 and 33-22-904, MCA
IMP: 33-22-902, ~~and~~ 33-22-903, and 33-22-923, MCA

6.6.505 POLICY DEFINITIONS AND TERMS (1) through (2)(c) remain the same.

(d) "health care expenses" means, for purposes of ARM 6.6.508, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(d) and (e) remain the same, but are renumbered (e) and (f).

~~(f)~~(g) "~~M~~medicare eligible expenses" means expenses of the kinds covered by medicare parts A and B, to the extent recognized as reasonable by medicare.

(g) remains the same, but is renumbered (h).

~~(h)~~(i) "~~S~~sickness" must not be defined more restrictively than the following: "Sickness means illness or disease of an insured person ~~which first manifests itself after the effective date of insurance and while the insurance is in force~~." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

AUTH: 33-1-313 and 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 and 33-22-924, MCA

6.6.506 PROHIBITED POLICY PROVISIONS (1) through (3) remain the same.

(4) Subject to ARM 6.6.507(1)(a)(iv) and (v):

(a) a medicare supplement policy or certificate with benefits for outpatient prescription drugs in existence prior to January 1, 2006, must be renewed for current policyholders or certificateholders who do not enroll in part D at the option of the policyholder or certificateholder;

(b) a medicare supplement policy or certificate with benefits for outpatient prescription drugs may not be issued after December 31, 2005; and

(c) after December 31, 2005, a medicare supplement policy or certificate with benefits for outpatient prescription drugs may not be renewed after the policyholder or certificateholder enrolls in medicare part D unless:

(i) the policy or certificate is modified to eliminate outpatient drugs incurred after the effective date of the individual's coverage under a part D plan; and

(ii) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of medicare part D enrollment, accounting for any claims paid, if applicable.

AUTH: 33-1-313, 33-22-904 and 33-22-905, MCA
IMP: 33-15-303, 33-22-902, 33-22-904 and 33-22-905, MCA

6.6.507 MINIMUM BENEFIT STANDARDS (1) through (1)(a)(i) remain the same.

(ii) a medicare supplement policy or certificate must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents~~.~~;

(iii) a medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes~~.~~;

(iv) no medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured other than the nonpayment of premium~~.~~;

(v) and (v)(A) remain the same.

(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation~~.~~;

(vi) remains the same.

(A) provides for continuation of the benefits contained in the group policy~~,~~; or

(B) provides for such benefits as otherwise meets the requirements of this subsection~~.~~;

(vii) through (vii)(A) remain the same.

(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy~~.~~;

(viii) if a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy must not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced~~.~~; and

(ix) if a medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), the modified policy or certificate shall be deemed to satisfy the guaranteed renewal requirements of this rule.

(2) Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare part D benefits will be considered in determining a continuous loss.

(3) through (3)(c)(i) remain the same.

(ii) provide for resumption of coverage ~~which~~ that is substantially equivalent to coverage in effect before the date of suspension~~; and~~. If the suspended medicare supplement policy or certificate provided coverage for outpatient prescription drugs, reinstitution of the policy or certificate for medicare part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) remains the same.

(4) Standards for basic ("core") benefits common to ~~all~~ benefit plans A through L include the following:

(a) through (a)(ii) remain the same.

(iii) upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the medicare part A eligible expenses for hospitalization paid at the ~~diagnostic related group (DRG) day outlier per diem~~ applicable prospective payment system (PPS) rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for the balance;

(iv) through (b)(i) remain the same.

(ii) coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare part A;

(iii) through (v) remain the same.

(vi) coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits received by the insured per calendar year, to the extent not covered by medicare~~;~~. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy or certificate until January 1, 2006;

(vii) coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible to a maximum of $3,000.00 in benefits received by the insured per calendar year, to the extent not covered by medicare~~;~~. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy or certificate until January 1, 2006;

(viii) remains the same.

(ix) coverage for the following preventive health services not covered by medicare:

(A) remains the same.

(B) ~~any one or a combination of the following~~ preventive screening tests or preventive services, the selection and frequency of which is determined to be ~~considered~~ medically appropriate by the attending physician~~:~~;

~~(I) digital rectal examination;~~

~~(II) dipstick urinalysis for hematuria, bacteriuria and proteinuria;~~

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

~~(IV) serum cholesterol screening (every five years);~~

~~(V) thyroid function test;~~

~~(VI) diabetes screening;~~

~~(VII) tetanus and diphtheria booster (every 10 years);~~

~~(VIII) any other tests or preventive measures determined appropriate by the attending physician.~~

(C) through (D)(II) remain the same.

~~(E) an issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies.~~

(c) the following are the standards for plans K and L:

(i) standardized medicare supplement benefit plan K must consist of the following benefits:

(A) coverage of 100% of the part A hospital coinsurance amount for each day used from the 61st through the 90th day in any medicare benefit period;

(B) coverage of 100% of the part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the 91st through the 150th day in any medicare benefit period;

(C) upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the medicare part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) coverage for 50% of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(E) coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare part A until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(F) coverage for 50% of cost sharing for all part A medicare eligible expenses for hospice and respite care until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(G) coverage for 50%, under medicare part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(H) except for coverage provided in (4)(c)(i)(I), coverage for 50% of the cost sharing otherwise applicable under medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in (4)(c)(i)(J);

(I) coverage of 100% of the cost sharing for medicare part B preventive services after the policyholder pays the part B deductible; and

(J) coverage of 100% of all cost sharing under medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare parts A and B of $4000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the U.S. department of health and human services;

(ii) standardized medicare supplement benefit plan L must consist of the following:

(A) the benefits described in (4)(c)(i)(A), (B), (C) and (I);

(B) the benefits described in (4)(c)(i)(D), (E), (F), (G) and (H), but substituting 75% for 50%; and

(C) the benefits described in (4)(c)(i)(J), but substituting $2000.00 for $4000.00.

AUTH: 33-1-313, 33-22-904 and 33-22-905, MCA
IMP: 33-15-303, 33-22-902, 33-22-904 and 33-22-905, MCA

6.6.507A STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

(1) remains the same.

(2) No groups, packages or combinations of medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in ~~ARM 6.6.507~~(7) and medicare select policies or certificates.

(3) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans A through ~~J~~L listed in this rule and conform to the definitions in 33-22-903, MCA, and ARM 6.6.505. Each benefit shall be structured in accordance with the format provided in ARM 6.6.507(4)(a), (b), and (c) and list the benefits in the order shown in this rule. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(4) through (5)(e)(i) remain the same.

(ii) the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in ARM 6.6.507(4)(b)(ix).

(f) through (i)(ii) remain the same.

(iii) the outpatient prescription drug benefit may not be included in a medicare supplement policy or certificate sold after December 31, 2005.

(j) through (j)(ii) remain the same.

(iii) the outpatient prescription drug benefit may not be included in a medicare supplement policy or certificate sold after December 31, 2005.

(k) through (k)(ii) remain the same.

(iii) the outpatient prescription drug benefit shall not be included in a medicare supplement policy or certificate sold after December 31, 2005.

(l) through (l)(ii) remain the same.

(iii) the outpatient prescription drug benefit may not be included in a medicare supplement policy or certificate sold after December 31, 2005.

(6) The following descriptions detail the contents of two medicare supplement plans mandated by the MMA:

(a) standardized medicare supplement benefit plan K must consist of only those benefits described in ARM 6.6.507(4)(c)(ii); and

(b) standardized medicare supplement benefit plan L must consist of only those benefits described in ARM 6.6.507(4)(c)(ii).

(7) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefit shall not

include an outpatient prescription drug benefit.

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

6.6.507B OPEN ENROLLMENT (1) through (3) remain the same.

(4) This rule must not be construed as preventing the exclusion of benefits under a policy, except as provided in (2) and (3) and ARM 6.6.507C and 6.6.522 ~~and 6.6.507B(2) and (3),~~ 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 and 33-22-905, MCA
IMP: 33-22-902 and 33-22-904, MCA

6.6.507C GUARANTEED ISSUE FOR ELIGIBLE PERSONS

(1) remains the same.

(a) Eligible persons are those individuals described in (2) who enroll under the policy during the period specified in (3) and who submit evidence of the date of termination, ~~or~~ disenrollment, or medicare part D enrollment with the application for a medicare supplement policy.

(b) through (b)(ii) remain the same.

(iii) ~~shall~~ may not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

(c) if an eligible person who originally purchased an issue-age rated plan and then applies for another issue-age plan from the same issuer on a guaranteed issue basis, that issuer must rate the replacement policy or certificate using the age at which the original policy or certificate being replaced was rated.

(2) through (2)(a)(ii) remain the same.

(b) ~~T~~the individual is enrolled with a ~~medicare+choice~~ medicare advantage organization under a ~~medicare+choice~~ medicare advantage plan under part C of medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of all-inclusive care for the elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a ~~medicare+choice medicare advantage~~ plan:

(i) through (c) remain the same.

(i) one of the following organizations:

~~(i)~~(A) an eligible organization under a contract under section 1876 of the Social Security Act (medicare ~~risk or~~ cost);

(ii) remains the same, but is renumbered (B).

~~(iii)~~(C) an organization under an agreement under

section 1833(1)(A) of the Social Security Act (health care prepayment plan); or

~~(iv)~~(D) an organization under a medicare select policy~~,~~; and

(ii) the enrollment ceases under the same circumstance that would permit discontinuance of an individual's election of coverage under (2)(b).

(d) through (e) remain the same.

(i) subsequently enrolls, for the first time, with any ~~medicare+choice~~ medicare advantage organization under a ~~medicare+choice~~ medicare advantage plan under part C of medicare, any eligible organization under a contract under section 1876 of the Social Security Act (medicare risk or cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a medicare select policy; and

(ii) remains the same.

(f) ~~T~~the individual, upon first becoming ~~enrolled in~~ eligible for benefits under medicare part ~~B~~ A ~~for benefits~~ at age 65 ~~or older~~, enrolls in a ~~medicare+choice~~ medicare advantage plan under part C of medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(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)(d)(ii).

(3) The following describes the guaranteed issue time periods in the case of:

(a) an individual described in (2)(a), the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of some or all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or ~~and ends 63 days after the date of the applicable notice;~~

(ii) the date that the applicable coverage terminates or ceases; and

(iii) ends 63 days after the applicable notice;

(b) remains the same.

(c) an individual described in (2)(d)(i), the guaranteed issue period begins on the earlier of:

(i) through (d) remain the same.

(e) an individual described in (2)(g), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the medicare supplement issuer during the 60 day period

immediately preceding the initial part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under medicare part D; and

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

(4) through (5) remain the same.

(a) an eligible person defined in (2)(a), (b), or (c) is entitled to the issuance of a medicare supplement policy with any level of benefits up to the level of the previous policy without underwriting offered by any issuer. If such an eligible person chooses a medicare supplement policy with a higher level of benefits than the previous policy, the issuer may underwrite the new policy;

(b) an eligible person defined in (2)(d) is entitled to the issuance of the same medicare supplement policy in which the eligible person was most recently enrolled, if available from the issuer, or, if not so available, a policy described in (5)(a); ~~and~~

(c) subject to (5)(d), an eligible person defined in ~~subsections~~ (2)(e) and (f) is entitled to the issuance of ~~shall include~~ any medicare supplement policy offered by any issuer~~.~~;

(d) after December 31, 2005, an individual who was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit and who elects to enroll in part D, is entitled to the issuance of a medicare supplement policy described as follows:

(i) the same policy from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) at the election of the policyholder, an A, B, C, D, E, F (including F with high deductible), G, K, or L policy that is offered by any issuer.

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

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

6.6.508 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM (1) and (1)(a) remain the same.

(i) at least 75% of the aggregate amount of premiums earned in the case of group policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health care maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices; ~~or~~

(ii) at least 65% of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices; or~~.~~

(iii) incurred health care expenses where coverage is provided by a health maintenance organization must not

include:

(A) home office and overhead costs;

(B) advertising costs;

(C) commissions and other acquisition costs;

(D) taxes;

(E) capital costs;

(F) administrative costs; and

(G) claims processing costs.

(b) through (2) remain the same.

(a) the data contained in the reporting form contained in Appendix A of the NAIC Model Regulation To Implement The NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001 [see new rule I], for each type in a standard medicare supplement benefit plan. ~~These forms may be obtained by writing to the Montana Insurance Commissioner, 840 Helena Avenue, Helena, Montana 59601.~~

(b) if, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation (see [New Rule I]) must be done on a statewide basis for each type in a standard medicare supplement benefit plan.

(c) through (3)(a)(ii) remain the same.

(A) the experience used to calculate an expected loss ratio must be the separate experience of any plan. If there is more than one plan H, I, or J because of the requirements of the MMA, the experience of each plan issued before [the effective date of these amendments], and of each H, I, or J plan of any type issued on or after this date must be combined for the purpose of determining the expected loss ratio. The experience must also be provided separately for each of these plans for the department's records.

(iii) through (4) remain the same.

AUTH: 33-1-313, 33-22-904, and 33-22-906, MCA
IMP: 33-15-303, 33-22-902 and 33-22-906, MCA

6.6.508A FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES (1) An issuer ~~shall~~ may not deliver, or issue for delivery, a policy or certificate to a resident of this state unless the policy form or certificate has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(a) and (b) remain the same.

(2) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the MMA, only with the commissioner in the state in which the policy or certificate was issued.

(2) remains the same, but is renumbered (3).

~~(3)~~(4) Except as provided in (4)(a), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement

benefit plan. Forms H, I, and J may be approved both with and without outpatient prescription drug coverage.

(a) through (a)(iv) remain the same.

(b) ~~F~~for the purposes of this rule, a "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

(4) remains the same, but is renumbered (5).

(a) remains the same.

(b) ~~A~~an issuer that discontinues the availability of a policy form or certificate form pursuant to ~~(4)~~(5)(a) ~~shall~~ may not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

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

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

(a) remains the same.

(7) An issuer may not present for filing, or approval, a rate structure for its medicare supplement policies and certificates issued after [the effective date of the amendment of this rule] based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages must increase smoothly as age increases.

AUTH: 33-1-313, 33-22-904, 33-22-905 and 33-22-906, MCA
IMP: 33-22-904 and 33-22-906, MCA

6.6.509 REQUIRED DISCLOSURE PROVISIONS (1) through (5) remain the same.

(6) Issuers of accident and sickness policies or certificates or subscriber contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for medicare must provide to such applicants a medicare supplement "buyer's guide". This may be the pamphlet entitled "Guide to Health Insurance for People with Medicare," developed jointly by the national association of insurance commissioners and the ~~health care financing administration~~ center for medicaid and medicare services (CMS) of the U.S. department of health and human services, or any reproduction or official revision of that pamphlet in a type size no smaller than 12 point type. The "buyer's guide" must conform to the language, format, type size, type proportional spacing, bold character, and line spaces as specified in Appendix C of the NAIC Model Regulation (see [New Rule III])~~, which is incorporated by reference in ARM 6.6.519. Specimen copies may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., or subject to availability of supplies, from the Montana department of insurance. The guide is identified as Department of Health and Human Services/Health Care Financing Administration Form~~

~~Number HCFA-02110~~.

(a) through (7)(d) remain the same.

(8) Issuers shall comply with any notice requirements of the MMA.

(8) remains the same, but is renumbered (9).

(a) remains the same.

(b) ~~T~~the outline of coverage provided to applicants consists of a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed below in no less than 12 point type. All plans A-~~J~~L ~~shall~~ must be shown on the cover page, and the plans that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

(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]

~~Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This~~ These charts shows the benefits included in each of the standard medicare supplement plans. Every company must make available plan A. Some plans may not be available in your state.

See Outline of Coverage sections for details about ALL plans

Basic Benefits~~:~~ for Plan A-J: ~~Included in All Plans.~~
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), ~~or, in the case of hospital outpatient department services under a prospective payment system, applicable~~ co-payments 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 Co—insurance	Skilled Nursing Facility Co—insurance	Skilled Nursing Facility Co—insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part 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 Co-~~I~~insurance	Skilled Nursing Facility Co-~~I~~insurance	Skilled Nursing Facility Co-~~I~~insurance	Skilled Nursing Facility Co-~~I~~insurance	Skilled Nursing Facility Co-~~I~~insurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
Part B Deductible				Part B Deductible
Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
	At-Home Recovery		At-Home Recovery	At-Home Recovery
		~~Basic Drugs ($1,250 Limit)~~	~~Basic Drugs ($1,250 Limit)~~	~~Extended Drugs ($3,000 Limit)~~
				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 ~~or offer the same~~ benefits as plans F and J after one has paid a calendar year ~~$1650~~ $1730 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses ~~are~~ exceed ~~$1650~~ $1730. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not

include, in plan J, the plan's separate prescription drug deductible or, in plans F and J, the plan's separate foreign travel emergency deductible.

[COMPANY NAME]

Outline of Medicare Supplement Coverage - Cover Page 2

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

J	K**	L**
Basic Benefits	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% hospice cost-sharing 50% of medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive services	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for Part B preventive services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	$[4000] Out of Pocket Annual Limit***	$[2000] Out of Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than 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.

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

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

6.6.510 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE (1) Application forms must include the following questions designed to elicit information as to whether, as of the date of application, the applicant currently has ~~another~~ medicare supplement, ~~or~~ medicare advantage, medicaid coverage, or another ~~other~~ health policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements as the following may be used:

(a) (STATEMENTS)

(1) through (3) remain the same.

(4) If, after purchasing this policy, you become eligible for medicaid, ~~T~~the benefits and premiums under your medicare supplement policy must be suspended if requested during your entitlement to benefits under medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for medicaid. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. If you are no longer entitled to medicaid, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing medicaid eligibility. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for and have enrolled in a medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended medicare supplement

policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare part D while your policy was suspended, the reinstated policy will not have prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

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

(b) (QUESTIONS)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a medicare supplement policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark yes or no below with an "X"]

To the best of your knowledge:

~~(1) Do you have another medicare supplement insurance policy or certificate in force (including health care service contract, health maintenance contract)?~~

~~(2) If the answer to (1) is yes, with which company?~~

~~(3) Do you have any other health insurance policies that provide benefits which this medicare supplement policy would duplicate?~~

~~(4) If the answer to (3) is yes, with which company?~~

~~(5) What kind of policy?~~

~~(6) If the answer to questions (1) or (3) is yes, do you intend to replace these medical or health policies with this policy (certificate)?~~

~~(7) Are you covered by the state medicaid program?~~

~~(a) As a Specified Low-Income Beneficiary (SLMB)?~~

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

~~(c) For other Medicaid medical benefits?~~

(1)(a) Did you turn age 65 in the last 6 months?
YES _____ NO _____

(b) Did you enroll in medicare part B in the last 6 months? YES _____ NO _____

(c) If yes, what is the effective date? ___________

(d) Did you enroll in medicare part C in the last 6 months? YES _____ NO _____

(e) If yes, what is the effective date? ___________

(f) Did you enroll in medicare part D in the last 6 months? YES _____ NO _____

(g) If yes, what is the effective date? ___________

(2) Are you covered for medical assistance through the

state medicaid program?

[NOTE TO APPLICANT: If you are participating in a "spend-down" program and have not met your "share of cost," please answer NO to this question.] YES _____ NO _____ If yes,

(a) Will medicaid pay your premiums for this medicare supplement policy? YES _____ NO _____

(b) Do you receive any benefits from medicaid other than payments toward your medicare part B premium?
YES _____ NO _____

(3)(a) If you had coverage from any medicare plan other than original medicare within the past 63 days (for example, a medicare advantage plan, or a medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start ____/__/__ End ____/__/__

(b) If you are still covered under the medicare plan, do you intend to replace your current coverage with this new medicare supplement policy?

(c) Was this your first time in this type of medicare plan? YES _____ NO _____

(d) Did you drop a medicare supplement policy to enroll in the medicare plan? YES _____ NO _____

(4)(a) Do you have another medicare supplement policy in force? YES _____ NO _____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?
____

(c) If so, do you intend to replace your current medicare supplement policy with this policy?

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) YES _____ NO _____

(a) If so, with what company and what kind of policy?
____
____
____

(b) What are your dates of coverage under the other policy? Start ____/___ /___ End ____/___/___
(If you are still covered under the other policy, leave "end" blank.)

(2) through (5) remain the same, but are renumbered (6) through (9).

(c) NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE

(Insurance Company's Name and Address)

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare or

Medicare advantage supplement insurance and replace it with a policy to be issued by (Company Name). Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement or Medicare advantage coverage is a wise decision.
~~STATE~~ STATEMENT TO APPLICANT BY ISSUER, OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this medicare supplement policy will not duplicate your existing medicare supplement or, if applicable, medicare advantage coverage because you intend to terminate your existing medicare supplement coverage or leave your medicare advantage plan. ~~The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge.~~ The replacement policy is being purchased for the following reason(s) (check one):

__________ Additional benefits.
__________ No change in benefits, but lower premiums.
__________ Fewer benefits and lower premiums.
__________ Other. (please specify)
__________ My plan has outpatient prescription drug coverage and I am enrolling in part D.
__________ Disenrollment from a medicare advantage plan. Please explain reason for disenrollment. [optional only for direct mailers.]

____
____
____

(1) Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement (2) below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
(2) through (3) remain the same.

AUTH: 33-1-313, 33-22-904 and 33-22-907, MCA
IMP: 33-15-303, 33-22-904, 33-22-907, 33-22-921, 33-22-922, 33-22-923 and 33-22-924, MCA

6.6.511 SAMPLE FORMS OUTLINING COVERAGE (1) The following amounts, as published in the Federal Register, ~~volume 61, page 56690, 1996,~~ for services furnished in the

current calendar year ~~1997~~ under medicare's hospital insurance program (medicare part A), ~~shall~~ must apply to the charts for plans A through ~~J~~L in (2)(b) through ~~(2)(k)~~(m). In each chart, the rule cited in brackets as ARM [6.6.511(1)(a)], [6.6.511(1)(b)], [6.6.511(1)(c)], ~~or~~ [6.6.511(1)(d)], [6.6.511(1)(e)], [6.6.511(1)(f)], [6.6.511(1)(g)], [6.6.511(1)(h)], [6.6.511(1)(i)], or [6.6.511(1)(j)], represents the dollar amount specified in the cited rule subsection. The issuer must replace each bracket and rule cite with the correct dollar amount contained in the cited rule subsection when the issuer prints the charts:

(a) inpatient hospital deductible = $~~840.00~~912.00;

(b) daily coinsurance amount for the 61st through 90th days of hospitalization in a benefit period = $~~210.00~~228.00;

(c) daily coinsurance amount for lifetime reserve days = $~~420.00~~456.00;

(d) daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $~~105.00.~~114.00;

(e) 50% of inpatient hospital deductible = $456.00;

(f) 75% of inpatient hospital deductible = $684.00;

(g) 25% of inpatient hospital deductible = $228.00;

(h) 50% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $57.00;

(i) 75% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $85.50;

(j) 25% of daily coinsurance amount for the 21st through 100th days of extended care services in a skilled nursing facility in a benefit period = $28.50.

(2) and (2)(a) remain the same.

(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 $[6.6.511(1)(a)]	$0	$[6.6.511(1)(a)] (Part A deductible)
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: ---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	$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 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 $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A & B

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

(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: ---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	$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 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 B

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

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

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

PARTS A & B

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

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

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

PLAN C

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

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

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

PARTS A & B

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

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 61st thru 90th day 91st day and after: ---While using 60 lifetime reserve days ---Once lifetime reserve days are used: ---Additional 365 days ---Beyond the additional 365 days	 All but $[6.6.511(1)(a)] All but $[6.6.511(1)(a)] a day All but $[6.6.511(1)(c)] a day $0 $0	$[6.6.511(1)(a)] (Part A deductible) $[6.6.511(1)(b)] a day $[6.6.511(1)(c)] a day 100% of Medicare eligible expenses $0	$0 $0 $0 $0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	 All approved amounts All but $[6.6.511(1)(d)] ~~/~~a day $0	 $0 Up to $[6.6.511(1)(d)] a day $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

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 $[100] of Medicare approved amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare approved amounts*	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan ---Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(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 miscel-lanous 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	$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 CALENDAR YEAR~~ PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	~~AFTER YOU PAY $1650 DEDUCTIBLE, **~~ PLAN PAYS	~~IN ADDITION TO $1650 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 $[100] of Medicare approved amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
~~Part B excess charges (Above Medicare approved amounts)~~	~~$0~~	~~$0~~	~~All costs~~
Part B Excess Charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[100] of Medicare approved amounts*	$0	$0	~~$0~~$[100] (Part B deductible
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES -- ~~BLOOD~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

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 ~~such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education,~~ administered or ordered by your doctor when not covered by Medicare First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

(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 ~~or offers the same~~ benefits as plan F after one has paid a calendar year ~~$1650~~ $[1730] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~$1650~~ $[1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~$1650~~ $[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$1650~~ $[1730] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATON* Semiprivate room and board, general nursing and ~~misc.~~ 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(a)(c)] a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$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 F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
[**This high deductible plan pays the same ~~or offers the same~~ benefits as plan F after one has paid a calendar year ~~$1650~~ $[1730] deductible. Benefits from the high deductible plan F will begin until out-of-pocket expenses are ~~$1650~~ $[1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~$1650~~ $[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$1650~~ $[1730] 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 $[100] of Medicare approved amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
~~Part B excess charges (above Medicare approved amounts)~~	~~$0~~	~~100%~~	~~$0~~
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $[100] of Medicare approved amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - ~~BLOOD~~ TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1650~~ $[1730] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1650~~ $[1730] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES ---Medically necessary skilled care services and medical supplies	100%	$0	$0
---Durable medical equipment First $[100] of Medicare approved amounts*	$0	$[100](Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$1650~~ $[1730] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$1650~~ $[1730] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$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	All but $[6.6.511(1)(c)] a day	$[6.6.511(a)(c)] a day	$0
---Once lifetime reserve days are used: ---Additional 365 days	$0	100% Medicare eligible expenses	$0**
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[6.6.511(1)(d)] /a day	Up to $[6.6.511(1)(d)] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$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 G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[100] of Medicare approved amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
~~Part B excess charges (above Medicare approved amounts)~~	~~$0~~	~~100%~~	~~$0~~
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $[100] of Medicare approved amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - ~~BLOOD~~ 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 $[100] of Medicare approved amounts*	$0	$0	$[100] Part B deductible
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
---Benefit for each visit	$0	Actual charges to $40 a visit	Balance
---Number of visits covered (Must be received within 89 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	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	$0	3 pints	$0
Additional amounts	100%	$0	$0

Continued on next page

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 $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

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 $[100] of Medicare approved amounts*	$0	$0	$[100] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

~~PLAN H~~

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(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~~a day	Up to $[6.6.511(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

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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 $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(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 ~~or offers the same~~ benefits as plan J after one has paid a calendar year ~~$1650~~ $[1730] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are ~~$1650~~ $[1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~$1650~~ $[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$1650~~ [$1730] 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

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SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~$1650~~ $[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$1650~~ $[1730] DEDUCTIBLE,**] YOU PAY
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	$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 $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
[**This high deductible plan pays the same ~~or offers the same benefits~~ as plan J after one has paid a calendar year ~~$1650~~ $[1730] deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are ~~$1650~~ $[1730]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~$1650~~ $[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$1650~~ $[1730] DEDUCTIBLE, **] YOU PAY
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
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare approved amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
~~Part B excess charges (above Medicare approved amounts)~~	~~$0~~	~~100%~~	~~$0~~
Part B excess charges (above Medicare approved amounts)	$0	100%	$0

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

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~$1650~~ $[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$1650~~ $[1730] DEDUCTIBLE, **] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[100] of Medicare approved amounts*	$0	$[100] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
~~AT HOME RECOVERY SERVICES NOT COVERED BY MEDICARE~~ ~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved 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~~	

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 ~~$1650~~ $[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~$1650~~ $[1730] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$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
~~EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE~~ ~~First $250 each calendar year~~	~~$0~~	~~$0~~	~~$250~~
~~Next $6,000 each calendar year~~	~~$0~~	~~50% $3,000 calendar year maximum benefit~~	~~50%~~
~~Over $6,000 each calendar year~~	~~$0~~	~~$0~~	~~All costs~~
***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services ~~such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education,~~ administered or ordered by your doctor when not covered by Medicare First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

(l) PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

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

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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	All but very limited coinsurance for outpatient 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 $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare approved amounts*	$0	$0	$[100] (Part B deductible)****
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 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 [$4000])*
BLOOD			
First 3 pints	$0	50%	50%◆
Next $[100] of Medicare approved amounts*	$0	$0	$[100] (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 $[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[100] of Medicare approved amounts*****	$0	$0	$[100] (Part B deductible)◆
Remainder of Medicare approved amounts	80%	10%	10%◆

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

(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 $[2000] 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

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SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but $[6.6.511(1)(d)] a day $0	$0 Up to $[6.6.511(1)(i)] a day $0	$0 Up to $[6.6.511](1)(j)]◆ 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 $[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[100] of Medicare approved amounts****	$0	$0	$[100] (Part B deductible)****◆
Preventive benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2000])*
BLOOD First 3 pints	$0	75%	25%◆
Next $[100] of Medicare approved amounts****	$0	$0	$[100] (Part B deductible)◆
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $[100] of Medicare approved amounts*****	$0	$0	$[100] (Part B deductible)◆
Remainder of Medicare approved amounts	80%	15%	5%◆

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

AUTH: 33-1-313 and 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 and 33-22-924, MCA

6.6.519 STANDARDS FOR MARKETING (1) through (1)(f) remain the same.

(g) provide to the enrollee an appropriate disclosure statement if the enrollee has accident and sickness insurance. These statements must be identical to the disclosure statements in Appendix C of the NAIC Model Regulation ~~T~~to Implement ~~T~~the NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001, (see [New Rule III]). ~~These disclosure statements are hereby adopted and incorporated by reference. These disclosure statements may be obtained by writing to the Montana Insurance Commissioner, 840 Helena Avenue, Helena, Montana 59601.~~

(2) through (3) remain the same.

AUTH: 33-1-313, 33-18-235 and 33-22-904, MCA
IMP: 33-15-303, 33-18-202, 33-18-204, 33-22-907, 33-22-908, 33-22-921, 33-22-922, 33-22-923 and 33-22-924, MCA

6.6.520 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE (1) remains the same.

(2) Any sale of medicare supplement ~~coverage~~ policy or certificate that will provide an individual more than one medicare supplement policy or certificate is prohibited.

(3) An issuer may not issue a medicare supplement policy or certificate to an individual enrolled in medicare part C unless the effective date of the coverage is after the termination date of the individual's part C coverage.

AUTH: 33-1-313 and 33-22-904, MCA
IMP: 33-15-303, 33-22-901 ~~through~~, 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 and 33-22-924, MCA

6.6.521 REPORTING OF MULTIPLE POLICIES (1) On or before March 1 of each year, every issuer shall report, on the form contained in Appendix B of the NAIC Model Regulation ~~T~~to Implement ~~T~~the NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001 (see [New Rule II]), information for every individual resident of this state for which the issuer has in force more than one medicare supplement insurance policy or certificate. ~~This form is hereby adopted and incorporated by reference. This form may be obtained by writing to the Montana Insurance Commissioner, 840 Helena Avenue, Helena, Montana 59601.~~ The following information must be reported:
(a) through (2) remain the same.

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

6.6.608 DISCLOSURE REQUIREMENTS (1) through (1)(b) remain the same.
(c) a description of the restricted network provisions, including payments for coinsurance and deductibles, when providers other than network providers are utilized~~;~~, except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L;
(d) through (g) remain the same.

AUTH: 33-22-904 and 33-22-905, MCA
IMP: 33-15-303, 33-22-901 ~~through~~, 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 and 33-22-924, MCA

6.6.612 INSURED MAY PURCHASE A COMPARABLE OR LESSER BENEFIT POLICY OR CERTIFICATE WITHOUT A RESTRICTED NETWORK PROVISION (1) remains the same.
(2) For the purpose of this rule, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purpose of (2), a significant benefit means coverage for the medicare part A deductible, ~~coverage for prescription drugs,~~ coverage for at-home recovery services, or coverage for part B excess charges.

AUTH: 33-22-904 and 33-22-905, MCA

IMP: 33-15-303, 33-22-901 ~~through~~, 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 and 33-22-924, MCA

6.6.613 PROVISION FOR CONTINUED COVERAGE (1) and (2) remain the same.

(3) For the purpose of this rule, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purpose of (3), a significant benefit means coverage for the medicare part A deductible, ~~coverage for prescription drugs,~~ coverage for at-home recovery services, or coverage for part B excess charges.

(4) remains the same.

AUTH: 33-22-904 and 33-22-905, MCA
IMP: 33-15-303, 33-22-901 ~~through~~, 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 and 33-22-924, MCA

4. The proposed new rules provide as follows:

NEW RULE I APPENDIX A - MEDICARE SUPPLEMENT REFUND CALCULATION FORM (1) This is the appendix referred to in ARM 6.6.508(2) and (3).

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR ______

TYPE[1] ____________________ SMSBP[2] ____________________
For the State of ____________ Company Name ____________________
NAIC Group Code ____________ NAIC Company Code ____________
Address ____________________ Person Completing Exhibit ______
Title ____________________ Telephone Number ______________

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes - 1a-1b		
2.	Past Year's Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		

6.	Refunds Since Inception (Excluding Interest)	
7.	Benchmark Ratio Since Inception (see worksheet for Ratio 1)	
8.	Experienced Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b) Total Earned Premium (line 3, col. a) - Refunds Since Inception (line 6)	
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund	
10.	Tolerance Permitted (obtained from credibility table)	

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000+	0.0%
5,000-9,999	5.0%
2,500-4,999	7.5%
1,000-2,499	10.0%
500-999	15.0%
If less than 500, no credibility.	

1. Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2. "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
3. Includes Modal Loadings and Fees Charged
4. Excludes Active Life Reserves
5. This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premium (line 3, col. a) - Refunds Since Inception (line 6)] x Ratio 3 (line 11)
13.	Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)-[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

____
Signature

____
Name - Please Type

____
Title - Please Type

____
Date

For the table
"Reporting Form for the Calculation of Benchmark Ratio Since Inception for Group Policies for Calendar Year _________"
Please contact the ARM Bureau at (406) 444-2842 or mopetersen@mt.gov

For the table
"Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies for Calendar Year __________"
Please contact the ARM Bureau at (406) 444-2842 or mopetersen@mt.gov

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

NEW RULE II APPENDIX B - FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES (1) This is the appendix referred to in ARM 6.6.521.

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: ____________________________

Address: ____________________________

____

Phone Number: ____________________________

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

____
Signature

____
Name and Title (please type)

____
Date

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

NEW RULE III APPENDIX C DISCLOSURE STATEMENTS

(1) This is the appendix referred to in ARM 6.6.509(6).

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

(1) Section 1882(d) of the federal Social Security Act (42 U.S.C. 1395ss) prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

(2) All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

(3) State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

(4) Property/casualty and life insurance policies are not considered health insurance.

(5) Disability income policies are not considered to provide benefits that duplicate Medicare.

(6) Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

(7) The federal law does not preempt state laws that are more stringent than the federal requirements.

(8) The federal law does not preempt existing state form filing requirements.

(9) Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

(a) [Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check for coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(b) [Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(c) [Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(d) [Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(e) [Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(f) [Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(g) [Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(h) [Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE INSURANCE

Some health care service paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(i) [Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(j) [Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(k) [Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(l) [Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(m) [Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(n) [Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

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

5. REASONABLE NECESSITY STATEMENT: It is necessary to amend and adopt the above-stated rules in order to be in

compliance with changes to corresponding federal regulations pursuant to the Medicare Modernization Act of 2003 (MMA) that are relevant to medicare supplement coverage.

6. Concerned persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Christina Goe, State Auditor's Office, 840 Helena Avenue, Helena, MT 59601, or by e-mail to cgoe@mt.gov, and must be received no later August 12, 2005.

7. Christina L. Goe has been designated to preside over and conduct the hearing.

8. The State Auditor's Office 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 which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices regarding insurance rules, securities rules, or both. Such written request may be mailed or delivered to Darla Sautter at the State Auditor's Office, 840 Helena Avenue, Helena, MT 59601, faxed to (406) 444-3497, e-mailed to dsautter@mt.gov or may be made by completing a request form at any rules hearing held by the State Auditor's Office.

9. The bill sponsor notice requirements of 2-4-302, MCA, apply and have been fulfilled.

JOHN MORRISON, State Auditor
and Commissioner of Insurance

By: ______________________
Alicia Pichette
Deputy Insurance Commissioner

By: /s/ Patrick M. Driscoll
Patrick M. Driscoll
Rules Reviewer

Certified to the Secretary of State on July 1, 2005.

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

In the matter of the proposed amendment of ARM 24.141.401 pertaining to board meetings, ARM 24.141.402 pertaining to apprentice registration, ARM 24.141.405 pertaining to fee schedule, ARM 24.141.502 pertaining to temporary practice permits, and ARM 24.141.503 pertaining to examinations	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On August 11, 2005, at 9:00 a.m., a public hearing will be held in room 489 of the Park Avenue Building, 301 South Park Avenue, Helena, Montana to consider the proposed amendment of the above-stated rules.

2. The Department of Labor and Industry will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or who need an alternative accessible format of this notice. If you require an accommodation, contact Mr. George Edwards no later than 5:00 p.m., August 4, 2005, to advise us of the nature of the accommodation you need. Please contact Mr. George Edwards, State Electrical Board, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2329; Montana Relay 1-800-253-4091; TDD (406) 444-2978; Facsimile (406) 841-2309; e-mail dlibsdele@mt.gov.

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

24.141.401 BOARD MEETINGS (1) remains the same.

(2) Special meetings or conference calls of the board shall be held at the call of the ~~chairman~~ president of the board~~, no prior notice of same required~~.

(3) remains the same.

AUTH: 37-68-201, MCA
IMP: 37-68-201, MCA

REASON: An administrative rule change is needed to correct language in the rule clarifying the title of the board president. 37-68-201, MCA identifies the titles of the officers of the board. Meetings held by the board will be subject to open meetings laws and rules and will receive prior public notice.

24.141.402 APPRENTICE REGISTRATION (1) and (2) remain the same.

(3) In order to be recognized by the board as an apprentice, an applicant shall either:

(a) present evidence of enrollment in an apprentice training program registered by the apprenticeship ~~bureau~~ and training program, department of labor and industry, state of Montana; or

(b) present evidence directly to the board of the individual's enrollment in an apprentice training program which is equivalent to programs of the Montana department of labor and industry.

~~(4) For purposes of determining whether a program is equivalent within the meaning of (3)(b) above, the board will consider and apply the current apprenticeship bureau standards. If the applicant employer's proposed program meets or exceeds the apprenticeship bureau's program then equivalency will be determined to have been met. In determining whether a proposed program meets or exceeds the apprenticeship bureau standards, the board will consider all factors used by the apprenticeship bureau. Interpretation of existence of these standards will be made with an overall expectation that proper safety standards for the apprentice are met and that the consumer is receiving proper and adequate electrical installation services from the apprentice and the apprentice's employer.~~

~~(5) With respect to the apprenticeship programs established directly through the board, the board reserves the right to monitor said programs and to demand and receive any and all necessary progress reports from the approved program.~~

~~(6) Compliance with federal and state law administered by the department of labor and industry, labor standards division, apprenticeship bureau, where such compliance is applicable shall be a condition to registering apprentices with the state electrical board.~~

AUTH: 37-68-201, MCA
IMP: 37-68-303, MCA

REASON: The Apprenticeship and Training Program is requesting that the State Electrical Board entertain these proposed rule changes in removing ineffective rules and designate the Apprenticeship and Training Program, Montana Department of Labor and Industry, as the primary entity for electrical apprentice purposes under their rules. Please note the following:

1. ARM 24.141.402 became effective September 12, 1980 with prior recognized registration authority of the apprenticeship and training program, but a Montana contractor has never used the rule. Although the rule offers a choice for apprenticeship recognition, it is in conflict with the norms currently and historically utilized by the Montana electrical industry for apprenticeship registration.

2. Board recognized apprentices would not qualify for payroll certification of apprentice wages on State Prevailing Wage projects and Federal Davis-Bacon predetermined wage projects. Also, board recognized workers would not be eligible for veteran's training benefits. Contractors would be required to pay the full journeyman worker wage and benefit package to board registered apprentices on those projects.

Board approved apprenticeship programs for Montana employers would be a duplication of the functional, statutory Apprenticeship and Training Program already existing. In 2004, the Apprenticeship and Training Program registered 179 combined inside and residential electrician apprentices for Montana electrical sponsors. In 2004, the program conducted an estimated 275 compliance related visits to registered electrical sponsors, with these visits encompassing wage compliance, required related instruction progress and providing technical program information. Furthermore, since January 1, 2002, the Apprenticeship and Training Program has graduated/completed 197 electrical apprentices to journey level status.

Currently the Apprenticeship and Training Program has over 375 electrical apprentices registered with an estimated 200 Montana electrical employers, and has the necessary technical expertise to manage those programs in compliance with applicable state and federal laws.

ARM 24.141.402 does allow for dual apprenticeship recognition, but any form of program services, without the necessary staffing that could be offered by the board, would be considered questionable in quality of program services. The current rule may allow a less than standard apprenticeship to exist within the Montana electrical community, which could also allow less than acceptable program performance. Given the fact that program performance has a direct tie to successfully passing the electrical journeymen's exam, a board driven apprenticeship, without oversight and administrative support, could fall short in providing the Montana electrical industry competent and well trained journeymen.

<u>24.141.405 FEE SCHEDULE</u> (1) Examination fees are set by the testing agency and vary by examination. Contact the board office for a current schedule of test section fees. Fees are to be paid directly to the testing agency upon the board's approval of an application.

<u>(a) Examination review fee</u> <u>$100</u>
<u>(b) Examination administered by the board</u> <u>200</u>
(2) through (9) remain the same.

AUTH: 37-1-134, 37-68-201, MCA
IMP: 37-1-134, 37-1-304, 37-1-305, 37-68-304, 37-68-307, 37-68-310, 37-68-311, 37-68-312, 37-68-313, MCA

REASON: An administrative rule change will be needed to allow for an exam review and a paper and pencil exam to be administered by department personnel. Exam candidates were unable to obtain an exam review in a timely manner. Individuals requesting a review would not be able to participate in a review until the next exam was conducted four months later. Exam candidates would then have to wait an additional four months before being allowed to re-exam with the vendor. The current exam vendor does not conduct exam reviews. Department personnel will be conducting the review, which will allow for the individual to retake the exam in a timely manner. Because of difficulty in obtaining an exam review with the former vendor, exam reviews have not been taking place.

351 examinations were given during 2004. Of the 351 examinations given, 232 individuals could have requested an exam review. No exam reviews were conducted during 2004. The State Electrical Board was given an exam question database from the State of Washington, which the board is now using. Currently, the State of Washington has not conducted an exam review using the questions in the database. Exam review fees will only impact applicants who have failed an exam and have requested a review.

A fee is needed to cover the board expense for staff time to prepare and conduct examination reviews. With a new exam process, potentially five individuals or less will request a review with the department.

The former exam vendor would provide a reader for individuals requiring ADA considerations. Department staff will now be conducting exams requiring a reader. A fee is needed to cover the board expense for staff time to prepare and conduct an exam administered by department staff. Less than two examinations per year have required a reader for exams in the past three years.

24.141.502 TEMPORARY PRACTICE PERMIT (1) and (2) remain the same.

(3) A temporary practice permit issued to an applicant for an electrician license shall expire 90 days from the date of issuance or upon receipt of licensure examination results. ~~on the date the next scheduled licensure examination results are received or in the case of licensure by reciprocity or endorsement, on the date that notice is received of the board's decision.~~

(4) through (6) remain the same.

(7) If the applicant does not register for the ~~next scheduled~~ examination within 90 days, the second temporary practice permit shall expire~~s on the date the board office is notified by the testing agency of the registration of the applicants~~.

AUTH: 37-1-319, 37-68-201, MCA
IMP: 37-1-305, MCA

REASON: An administrative rule change is needed to specify a time period for a temporary practice permit to be valid. Past examinations were only available four times per year, and temporary practice permits were valid anywhere from one to six months. Examinations will now be available on a weekly and possibly daily basis. Because of the availability of examinations, a time frame for temporary practice permits must be established.

24.141.503 EXAMINATIONS (1) through (4) remain the same.

(5) All examinations are open book.

(a) Candidates may only use:

(i) an NEC code book applicable to the examination being given (tabs or indexes may be used in the book);

(ii) a silent, nonprinting, nonprogrammable calculator that is not designed for preprogrammed electrical calculations; and

(iii) copies of the Montana statutes and rules relating to electricians.

(6) An applicant for an examination who, due to a specific physical, mental, or sensory impairment, requires special accommodation in examination procedures must submit a written request to the board office for the specific accommodation needed.

(7) Any candidate who takes an examination and does not pass the examination may request a review of the examination.

(a) The department will not modify examination results unless the candidate presents clear and convincing evidence of error in the grading of the examination.

(b) The department will not consider any challenge to examination grading unless the total of the potentially revised score would result in a passing score.

(8) The procedure for requesting an informal review of examination results is as follows:

(a) The request must be made in writing to the board office and received within 20 days of the date of the examination and must request a rescore of the examination.

(b) The following procedures apply to review of the results of the examination:

(i) The candidate will be allowed two hours to review the examination.

(ii) The candidate must identify the challenged questions of the examination and must state specific reasons why the results should be modified with the NEC code book and/or Montana statutes and rules supporting the candidates position.

(iii) Within 15 days of the candidate's review, the department will review the examination and candidate's justification and notify the candidate in writing of the department's decision.

(9) Anyone determined by the board to be cheating on an examination or using inappropriate material/equipment during an examination will fail and be required to wait at least one year and reapply for licensure before being allowed to reexamine. All such reexaminations will be administered by the department in Helena, Montana, require a written examination fee, and the candidate will be required to apply and schedule the examination with the board office.

(10) Examination appeals must be submitted and reviewed by the full board at its next regularly scheduled meeting.

AUTH: 37-1-131, 37-68-201, MCA
IMP: 37-68-201, 37-68-304, 37-68-305, MCA

REASON: All aspects of electrician examinations were previously contracted out to a third party exam vendor. In order to implement changes to allow more frequent exam availability, the board is using a new third party vendor. This vendor will only proctor an examination. The board is establishing rules to establish a procedure for examinations to benefit exam candidates who had previously had difficulty obtaining examination reviews and appeals.

To clearly identify what an exam candidate is allowed to bring into an exam site, the board identified specific books and types of calculators allowed into an exam site.

One incidence of cheating on an exam was reported to the board in 2004. A procedure is needed to establish consequences for individuals found to be cheating or using inappropriate materials during an examination.

4. Concerned persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted by mail to Mr. George Edwards, State Electrical Board, Department of Labor and Industry, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2309, or by e-mail to dlibsdele@mt.gov and must be received no later than 5:00 p.m., August 19, 2005.

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

person's technical difficulties in accessing or posting to the e-mail address do not excuse late submission of comments.

6. The State Electrical Board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this Board. Persons who wish to have their name added to the list shall make a written request that includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding all State Electrical Board administrative rulemaking proceedings or other administrative proceedings. Such written request may be mailed or delivered to the State Electrical Board, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, faxed to the office at (406) 841-2309, e-mailed to dlibsdele@mt.gov or may be made by completing a request form at any rules hearing held by the agency.

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

8. Lon Mitchell, attorney, has been designated to preside over and conduct this hearing.

STATE ELECTRICAL BOARD
TONY MARTEL, PRESIDENT

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

/s/ MARK CADWALLADER
Mark Cadwallader
Rule Reviewer

Certified to the Secretary of State July 1, 2005

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

In the matter of the proposed amendment of ARM 24.204.401 fee schedule, ARM 24.204.404 permit fees, ARM 24.204.406 abatement of renewal fees, ARM 24.204.408 radiologic technologists applications, ARM 24.204.411 replacement licenses and permits, ARM 24.204.504 permits - practice limitations, ARM 24.204.511 permit examinations, and the proposed adoption of NEW RULES I through IV pertaining to radiologist assistants, scope of practice, supervision, and adoption of a code of ethics	)	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT AND ADOPTION

TO: All Concerned Persons

1. On August 8, 2005, at 10:00 a.m., a public hearing will be held in room 489, Park Avenue Building, 301 South Park, Helena, Montana to consider the proposed amendment and adoption of the above-stated rules.

2. The Department of Labor and Industry will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board of Radiologic Technologists no later than 5:00 p.m. on August 5, 2005, to advise us of the nature of the accommodation that you need. Please contact Helena Lee, Board of Radiologic Technologists, 301 South Park, P.O. Box 200513, Helena, Montana 59620-0513; telephone (406) 841-2385; Montana Relay 1-800-253-4091; TDD (406) 444-2978; facsimile (406) 841-2305; e-mail dlibsdrts@mt.gov.

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

24.204.401 FEE SCHEDULE (1) remains the same.

AUTH: 37-1-134, 37-14-202, MCA
IMP: 37-1-134, 37-14-305, ~~37-14-309, 37-14-310,~~ MCA

REASON: The Board of Radiologic Technologists (Board) has determined it is reasonably necessary to amend the implementation cites to accurately reflect all statutes

implemented through the rule and to delete references to repealed statutes.

24.204.404 PERMIT FEES
(1) remains the same.
(2) Combined ~~Examination~~ examination fee and re-examination fee 15
~~(a) General exam 15~~
~~(b) Each section 15~~
(3) through (5) remain the same.
~~(6) Duplicate or lost license fee 5~~
(7) and (8) remain the same but are renumbered (6) and (7).
(8) Document 20

AUTH: 37-1-131, 37-1-134, 37-14-202, 37-14-306, ~~37-14-310,~~ MCA
IMP: 37-1-134, 37-14-305, 37-14-306, ~~37-14-309, 37-14-310,~~ MCA

REASON: The Board has determined it is reasonably necessary to amend ARM 24.204.404 in order to set the Board's fees at a level commensurate with program costs as required by 37-1-134, MCA. The Board's appropriation for fiscal year 2005 is $56,960. The Board waived the renewal fees in both fiscal years 2003 and 2004 and is now addressing its duty of establishing fees commensurate with Board costs. In fiscal year 2004, the Board's annual revenue for examination fees was $5,985. To date, in fiscal year 2005, the annual revenue for examination fees is $6,630. In fiscal year 2006, the Board's annual revenue for the combined examination fee is anticipated to be $1,200.

The Board has recently contracted with the American Registry of Radiologic Technologists (ARRT) for the ARRT to administer the ARRT Limited Scope Examination, which includes a core portion and individual module examinations for selected anatomic regions. The Board will offer a combined examination consisting of the Gastrointestinal tract (GI), Abdomen (AB), and Hip/Pelvis examinations, as those anatomic regions are not tested through the ARRT Limited Scope Examination. Limited permit applicants who have successfully passed the ARRT Limited Scope Examination and desire to be permitted in the GI, AB, and Hip/Pelvis anatomic regions would need to take the Board combined examination and pay the appropriate fee. The Board estimates that approximately 80 persons (20 GI examination applicants, 30 AB examination applicants and 30 hip/pelvis examination applicants) will be affected by the proposed combined examination. The examination fee remains the same for the combined examination as the former general and individual section examinations.

The Board is deleting the duplicate license/certificate fee, as licensees are now able to print multiple copies of a

license during the online renewal process. The Board does not have data on the number of duplicate licenses issued during the previous fiscal year; however, the Board has a general sense that an insignificant number of duplicates were issued.

The Board is adding a $20.00 document fee for lists, labels, or disc fees. There were approximately 6 requests for licensee lists, labels or discs in fiscal year 2004 and the Board estimates a $120 increase in revenue per fiscal year with the addition of this fee. Authority and implementation cites are being amended to accurately reflect all statutes implemented through the rule, to provide the complete sources of the Board's rulemaking authority and to delete references to repealed statutes.

24.204.406 ABATEMENT OF RENEWAL FEES (1) through (4) remain the same.

AUTH: ~~37-1-101 and~~ 37-1-131, 37-14-202, MCA
IMP: 17-2-302, 17-2-303, ~~37-1-101,~~ 37-1-134 ~~and 37-14-310~~, MCA

REASON: The Board has determined it is reasonably necessary to amend the authority and implementation cites to accurately reflect all statutes implemented through the rule, to provide the complete sources of the Board's rulemaking authority and to delete references to repealed statutes.

24.204.408 RADIOLOGIC TECHNOLOGISTS APPLICATIONS
(1) through (4) remain the same.
(5) An application for licensure shall be submitted to the board office with copies of the following documents:
~~(a) board-approved 24-month x-ray course certificate;~~
~~(b) current ARRT wallet card;~~
(c) remains the same but is renumbered (a).
~~(d)~~ (b) application fee; ~~and~~
~~(e)~~ (c) original certificate fee~~.~~ ; and either:
(d) evidence of certification by the American registry of radiologic technologists (ARRT) in x-ray technology. This evidence shall consist of the applicant being listed in the current ARRT directory. When the applicant is not listed in the current ARRT directory, he or she shall submit to the board a certified copy issued by the ARRT of the original registration certificate; or
(e) at the board's discretion, documentation of successful completion of a course of study in an approved school of radiologic technology as defined in 37-14-303, MCA, and having obtained a passing score on the examination in diagnostic radiologic technology given by the ARRT. A scaled score of 75 constitutes a passing score.
(6) remains the same.

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

IMP: 37-14-302, ~~37-14-303, 37-14-304,~~ 37-14-305, ~~37-14-306,~~ MCA

REASON: The Board has determined it is reasonably necessary to amend this rule to reconcile 37-1-203, MCA, with the Board's application requirements for radiologic technologist licensure. Pursuant to 37-1-203, MCA, Montana's licensing boards are prohibited from refusing licensure to an applicant solely on the basis of previous criminal conviction. Under the current rule, radiologic technologist applicants must submit, among other things, a current ARRT wallet card. However, applicants with past criminal convictions may not qualify for the official credential of the ARRT card due to the ARRT's ethical standards of conduct.

In response to a 2004 Montana district court decision and in order to accommodate applicants with criminal histories, the Board is amending this rule to no longer require a current ARRT card. The amended rule will require either evidence of the applicant's ARRT certification in x-ray technology or, at the Board's discretion, proof of successful completion of a radiologic technology course of study and passage of the ARRT diagnostic radiologic technology exam. Amendment of the rule ensures that license applicants meet the necessary education and exam requirements for qualified licensure, while advancing the intent and purpose of 37-1-203, MCA.

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

24.204.411 REPLACEMENT LICENSES AND PERMITS

(1) Licensees and permit holders shall immediately notify the board of lost, damaged, or destroyed licenses and permits ~~and obtain a duplicate by written request to the board, stating the reason for the need to issue a duplicate and by paying the appropriate fee~~.

AUTH: 37-1-131, 37-14-202, MCA
IMP: 37-14-305, 37-14-308, ~~37-14-309,~~ MCA

REASON: The Board is deleting the duplicate license/certificate fee in ARM 24.204.404, as licensees are now able to print multiple copies of a license during the online renewal process. It is reasonable and necessary to amend this rule to correspond with the online printing capabilities and the amendments to ARM 24.204.404. Authority and implementation cites are being amended to accurately reflect all statutes implemented through the rule, to provide the complete sources of the Board's rulemaking authority and to delete references to repealed statutes.

24.204.504 PERMITS - PRACTICE LIMITATIONS (1) through (3) remain the same.

(4) A student of ~~an ARRT recognized~~ a radiologic technologist program accredited by a mechanism recognized by the ARRT is allowed to perform procedures with portable fluoroscopy equipment (also known as c-arm), provided the student has submitted documentation to the board that:

(a) identifies the student as being enrolled in ~~an ARRT recognized~~ a radiology program accredited by a mechanism recognized by the ARRT;

(b) through (d) remain the same.

(5) If a student of ~~an ARRT recognized~~ a radiologic technologist program accredited by a mechanism recognized by the ARRT has completed the first two semesters of the program or its equivalent, as determined by the board, and has become a limited permit holder, that person may perform procedures while operating portable fluoroscopy equipment and may be compensated.

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

REASON: The Board has determined that there is reasonable necessity to amend terminology used in this rule to clarify that the ARRT does not itself recognize radiologic technologists programs. Students enroll in radiologic technology programs that are accredited by a mechanism recognized by the ARRT. An authority cite is being added to accurately reflect all sources of the Board's rulemaking authority.

24.204.511 PERMIT EXAMINATIONS (1) All limited permit applicants shall take and pass the ARRT limited scope of practice in radiology core examination.

(a) The ~~general portion of the permit~~ ARRT limited scope core examination contains questions common to all areas of specified x-ray procedures and includes the following topics:

(i) basic radiobiology~~,~~ ;

(ii) radiation protection~~,~~ ;

(iii) imaging equipment~~,~~ ;

(iv) x-ray physics~~,~~ ;

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

(vi) darkroom procedures; and

(vii) ~~inter-relationship~~ interrelationship of the radiographic chain. ~~All permit applicants shall pass the general portion of the permit examination.~~

(2) In addition to the ~~general portion~~ ARRT limited scope core examination, 40-hour course graduates shall complete ~~an~~ a module examination for ~~each specified x-ray procedure~~ selected anatomic regions in which the applicant desires to be permitted ~~to perform~~.

(a) ~~The specified examinations~~ Each module examination shall include questions common to the individual module in the following areas:

(i) anatomy~~,~~ ;

(ii) physiology~~,~~ ;

(iii) pathology; and

(iv) x-ray technique ~~common to the specified procedure~~.

(b) Limited permits are issued in Montana in the following five categories:

(i) chest;

(ii) extremities;

(iii) skull/sinuses;

(iv) spine; and

(v) abdomen, gastrointestinal tract and hip/pelvis (state combined examination).

~~(2) Applicants for examination may request to take the examination in the board office any day of the working week. This request must be in writing and must be received in the board office at least 10 days prior to the requested examination date.~~

~~(3) Examination results will be mailed out to each examinee by the board office within 10 days after the administration of the examination.~~

(3) "Combined examination" as used in this rule means the examination consisting of abdomen (AB), gastrointestinal tract (GI) (postfluoroscopy films only), and hip/pelvis examinations.

(4) Applicants may review their combined examination ~~papers~~ with administrative staff for the board at the board office or at an approved site designated by the board.

(5) A non–refundable fee will be assessed for the combined examination. After failing the combined examination, the applicant will be required to submit another combined examination retake fee.

(6) Applicants for a ~~limited~~ 40-hour course permit ~~(40-hour course)~~ who fail ~~an examination twice must~~ any portion of the ARRT limited scope examination (core or any module examination) on two attempts shall ~~retake that~~ be required to successfully complete additional coursework in the failed ~~portion~~ area(s) of the ~~formal x-ray training~~ examination before being allowed ~~admission~~ to retake the failed portion(s) of the examination a third ~~examination~~ time. ~~Upon completion of the additional course work in the failed area, the applicant must file a new application accompanied by the appropriate fees, with the board office.~~

(a) remains the same.

(7) Student permit ~~applications~~ applicants (having completed two semesters or its equivalent from a ~~in an ARRT~~ radiologic technology program accredited by a mechanism recognized by the ARRT) ~~radiologic technologist program)~~ who ~~have failed the general examination twice must re-take the general examination plus all six category exams~~ fail the ARRT limited scope core examination on two attempts shall retake:

(a) the core examination;

(b) all four individual module examinations; and

(c) the state combined examination.

(8) Temporary permit applicants (graduates of a radiologic technology program accredited by a mechanism recognized by the ARRT ~~recognized program graduates~~) who have failed the ARRT radiologic technologist ~~exam~~ examination three times ~~must~~ shall take:

(a) the ~~general exam plus all six category exams~~ ARRT limited scope core examination;

(b) all four individual module examinations; and

(c) the state combined examination.

(9) ~~A passing score of 75% is required on each of the general and specified sections of the examination. Retakes of any portion or section of an examination shall require a 75% passing score.~~ A minimum passing score of 70% is required on the ARRT limited scope core examination, each module examination, and the state combined examination.

(10) remains the same.

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

REASON: The Board has determined it is reasonably necessary to amend this rule to clarify the examination requirements for limited permit applicants. The ARRT limited scope of practice in radiology examination (core exam and individual modules) is a nationally recognized entry-level limited permit examination. The Board has determined to discontinue writing its own examination for limited permit licensure of Montana radiologic technologists and to accept the ARRT limited scope examination instead. The Board will administer a combined examination to cover those areas not tested in the ARRT limited scope examination. The Board is also amending the rule to clarify the requirements for retaking the limited permit examination upon failure of the core or module component examinations. The Board concluded that requiring additional study in any failed topic areas prior to retesting is the best way to ensure that only qualified applicants are granted limited practice permits.

The Board determined it is reasonably necessary to reduce the acceptable minimum passing score on the limited permit examination from 75% to 70%. As approved in the July 2002 update of ARRT Evaluation of the Passing Score for the Limited Scope Examination, the mean score for the 2002 ARRT limited scope core examination was 66%. The Board determined the ARRT limited scope core examination is sufficiently difficult and that continuing with the current 75% passing score would result in needless failure of a majority of limited permit examinees. Subsequently, the Board concluded that requiring a minimum passing score of 70% on the limited scope core examination, individual module examinations and the combined examination is sufficient to ensure qualified limited permit applicants for licensure. The Board has determined it is

reasonably necessary to define "combined examination" to clarify the Board's intent as to the meaning of the term used in this rule.

Several sections of the rule have been further earmarked and renumbered for clarity and ease of use. An authority cite is being added to accurately reflect all sources of the Board's rulemaking authority.

4. The proposed NEW RULES provide as follows:

NEW RULE I QUALIFICATIONS (1) A radiologist assistant (RA) may also be referred to as a radiology practitioner assistant (RPA) pursuant to 37-14-313, MCA, including current licensees or students currently enrolled in the 2005 school year.

(2) To practice as a RA/RPA, an applicant shall:

(a) be a graduate of a RA educational program that:

(i) culminates in the award of a baccalaureate degree, postbaccalaureate certificate, or master's degree from an institution accredited by a mechanism recognized by either:

(A) ARRT;

(B) American college of radiology; or

(C) American society of radiologic technologists; and

(ii) incorporates a radiologist-directed clinical preceptorship; and

(iii) meets the eligibility requirements for certification by the ARRT.

(A) The board will accept certification from the ARRT or the certification board for radiologist practitioner assistant (CBRPA) for eligibility to sit for the CBRPA certification or ARRT examination;

(b) maintain an active ARRT registration status in radiography;

(c) submit a copy of current certification in advanced cardiac life support (ACLS) skills;

(d) furnish validation of participation in continuing education activities with a minimum of 24 hours of continuing education credits annually;

(e) hold a current Montana radiologic technologist (RT) license; and

(f) submit to the board a letter from the supervising radiologist certifying completion of a clinical preceptorship.

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

REASON: The 2003 Montana Legislature enacted Chapter 307, Laws of 2003 (House Bill 501), regarding the practice of radiologist assistants. The bill was signed by the Governor on April 14, 2003, became effective on October 1, 2003, and is codified at Title 37, chapter 14, Montana Code Annotated (MCA). There is reasonable necessity to adopt New Rules I through IV to implement the 2003 legislation.

The Board has determined it is reasonably necessary to adopt New Rule I to further implement 37-14-313, MCA, by establishing qualifications for licensed radiologic technologists to perform the functions of radiologist assistants/radiology practitioner assistants (RA/RPA). The Board determined that the qualifications as set forth in New Rule I are necessary to protect the public by ensuring that only qualified licensed radiologic technologists are functioning as RA/RPAs.

NEW RULE II SCOPE OF PRACTICE - SPECIFIC DUTIES AND FUNCTIONS (1) The RA/RPA shall evaluate the day's schedule of procedures with the supervising radiologist or the radiologist designate and determine where the RA/RPA's skills will be best utilized.

(2) After demonstrating competency, the RA/RPA, under the general supervision of the supervising radiologist or the radiologist designate, may perform the following procedures:

(a) fluoroscopic procedures (static and dynamic);

(b) arthrograms, pursuant to 37-14-301, MCA; and

(c) peripheral venograms, pursuant to 37-14-301, MCA.

(3) The RA/RPA may make initial observations of diagnostic images and forward them to the supervising radiologist.

(4) The RA/RPA shall assess and evaluate the psychological and physiological responsiveness of each patient.

(5) The RA/RPA shall participate in patient management, including acquisition of additional imaging for completion of the exam and record documentation in medical records.

(6) The RA/RPA shall administer intravenous contrast media or glucagon under the supervision of a radiologist or the attending physician pursuant to 37-14-301, MCA.

(7) "Radiologist designate", as used in this rule, means a radiologist, MD who has been named radiologist designate by the supervising radiologist, MD. The radiologist designate must reside in Montana and have a current Montana license.

AUTH: 37-1-131, 37-14-202, 37-14-313, MCA
IMP: 37-14-102, 37-14-301, 37-14-313, MCA

REASON: The Board has determined that New Rule II is reasonably necessary to comply with and further implement 37-14-313, MCA, by specifying the allowable duties and functions of licensed radiologic technologists functioning as RA/RPAs. As required in 37-14-313, MCA, the proposed duties and functions are consistent with guidelines established by the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the ARRT. New Rule II provides the scope of practice for the RA/RPA as an "advanced-level licensed radiologic technologist who works under the general supervision of a radiologist to enhance patient care by assisting the radiologist in the diagnostic imaging

environment" per 37-14-102, MCA. The RA/RPA shall not interpret radiological examinations nor transmit observations to anyone other than to the RA/RPA's supervising radiologist.

The Board has determined it is reasonably necessary to define "radiologist designate" to clarify the Board's intent as to the meaning of the word used within the New Rules.

NEW RULE III SCOPE OF REQUIRED SUPERVISION (1) A RA/RPA may only perform diagnostic procedures under the general supervision of a licensed radiologist. In order for a RA/RPA to be considered under the general supervision of a radiologist, the RA/RPA must:

(a) meet with the supervising radiologist on a regularly scheduled basis of not less than once every month;

(b) provide the supervising radiologist with copies of records from procedures the RA/RPA has performed;

(c) seek input from the supervising radiologist regarding any issues relating to the RA/RPA’s performance of diagnostic procedures; and

(d) have a means of contacting the radiologist in order to obtain a timely consultation.

(i) Consultations with the supervising radiologist are considered timely if the radiologist replies to the RA/RPA within eight hours of the RA/RPA’s request for consultation.

(2) Consultations with the supervising radiologist shall be conducted as needed:

(a) in person;

(b) by telephone;

(c) by interactive videoconferencing; or

(d) by electronic means of communication, such as e-mail or picture, archives, and communication system (PACS).

(3) The RA/RPA shall not perform any diagnostic procedure for which a consultation is needed or appropriate, until such time as consultation has occurred and the RA/RPA has been advised or directed by the radiologist on how to proceed.

AUTH: 37-1-131, 37-14-202, 37-14-313, MCA
IMP: 37-14-102, 37-14-313, MCA

REASON: The Board has determined that adoption of New Rule III is reasonably necessary to comply with legislative intent of 37-14-313, MCA. The Board proposes New Rule III to further delineate and describe the general supervision requirements for the licensed radiologic technologists functioning as RA/RPAs in Montana. The proposed scope of required supervision is consistent with the supervision requirements of the ACR, ASRT, and ARRT, as required in 37-14-313, MCA.

NEW RULE IV CODE OF ETHICS (1) The board adopts and incorporates by reference the July 2003 edition of the code of ethics adopted by the ARRT.

(2) Copies of the ARRT code of ethics may be obtained on the ARRT website at www.arrt.org, or from the office of the board at 301 S. Park Avenue, Helena, or P.O. Box 200513, Helena, Montana 59620-0513.

(3) The RA/RPA shall adhere to and abide by the ARRT code of ethics.

(4) In addition to the ARRT code of ethics, the conduct of the RA/RPA shall be governed by the following additional ethical and professional principles. The RA/RPA shall:

(a) adhere to all state and federal laws governing informed consent concerning patient health care;

(b) seek consultation with the supervising radiologist, other health providers, or qualified professionals having special skills, knowledge or expertise whenever the welfare of the patient will be safeguarded or advanced by such consultation;

(c) provide only those services for which the RA/RPA is qualified via education, demonstration of clinical competency, and as allowed by rule;

(d) not misrepresent in any manner, either directly or indirectly, the RA/RPA's clinical skills, educational experience, professional credentials, identity, or ability and capability to provide radiology health care services;

(e) place service before material gain;

(f) carefully guard against conflicts of professional interest; and

(g) adhere to national, institutional and/or departmental standards, policies and procedures regarding the standards of care for patients.

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

REASON: The Board has determined that adoption of the ARRT code of ethics in New Rule IV is reasonable and necessary to further implement 37-14-313, MCA, and further delineate the allowable duties and scope of practice for RA/RPAs that are consistent with the guidelines of ARRT, ACR and ASRT. The ARRT code of ethics is uniformly interpreted and enforced by these three entities. Adoption of a code of ethics will provide an ethical framework for the practice of RA/RPAs that will also assist the Board in preserving public health and safety by promoting the quality practice of RA/RPAs.

5. Concerned persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Board of Radiologic Technologists, 301 South Park Avenue, P.O. Box 200513, Helena, Montana 59620-0513, by facsimile to (406) 841-2305, or by e-mail to dlibsdrts@mt.gov, and must be received no later than 5:00 p.m., August 16, 2005.

6. An electronic copy of this Notice of Public Hearing is available through the Department and Board’s site on the

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

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

8. The bill sponsor notice requirements of 2-4-302, MCA, apply and have been fulfilled.

9. Lon Mitchell, attorney, has been designated to preside over and conduct this hearing.

BOARD OF RADIOLOGIC TECHNOLOGISTS
JOHN ROSENBAUM, CHAIRPERSON

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

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

Certified to the Secretary of State July 1, 2005

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

In the matter of the adoption of Rules I through XI, the amendment of ARM 37.104.101, 37.104.105, 37.104.106, 37.104.201, 37.104.203, 37.104.208, 37.104.212, 37.104.213, 37.104.218, 37.104.221, 37.104.306, 37.104.307, 37.104.311, 37.104.312, 37.104.316, 37.104.319, 37.104.329, 37.104.336, 37.104.401, 37.104.404, 37.104.616 and 37.104.805 and the repeal of ARM 37.104.219, 37.104.220, 37.104.317, 37.104.318, 37.104.327, 37.104.328, 37.104.402 and 37.104.403 pertaining to emergency medical services	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, AND REPEAL

TO: All Interested Persons

1. On August 4, 2005, at 10:00 a.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption, amendment and repeal of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on July 25, 2005, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; Email dphhslegal@mt.gov.

2. The rules as proposed to be adopted provide as follows:

RULE I BASIC EQUIPMENT KIT (1) A basic equipment kit must include all of the following equipment and supplies:

(a) two air occlusive dressings;

(b) one blood pressure manometer with adult, extra large adult, and pediatric cuffs;

(c) one stethoscope;

(d) five dressings (assorted);

(e) two pairs of exam gloves;
(f) one pair of safety glasses to provide splash protection for the emergency care provider;
(g) one surgical mask;
(h) one oral glucose;
(i) one flashlight;
(j) four soft roller bandages;
(k) four rolls of adhesive tape of assorted sizes;
(l) four triangular bandages;
(m) four oropharyngeal airways of assorted child and adult sizes;
(n) one mouth to mask resuscitator with one-way valve, oxygen inlet and oxygen connecting tubing;
(o) one bulb syringe or equivalent suction apparatus;
(p) one portable oxygen system containing at least 200 liters of oxygen and with regulator and flowmeter;
(q) one adult and one pediatric oxygen mask;
(r) one nasal oxygen cannula;
(s) one pair of scissors;
(t) one pair of heavy leather gloves;
(u) one helmet for personnel that is capable of protection from head injury; and
(v) paper and pen or pencil.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

RULE II BASIC LIFE SUPPORT SERVICE LICENSING (1) An ambulance service or nontransporting medical unit (NTU) capable of providing service only at the basic life support level will be licensed at the basic life support level.
(a) A basic life support service or NTU that provides care at the EMT-B 2 level will receive a basic life support license.
(b) Other than as defined in (1)(a), an ambulance service or NTU that provides advanced life support but cannot reasonably provide it 24 hours per day, seven days per week due to limited personnel, will receive a basic life support license.
(2) Ambulance services or NTUs shall request authorization for (1)(a) or (b) by submitting a service plan on forms provided by the department.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

RULE III NONTRANSPORTING MEDICAL UNIT (1) A nontransporting medical unit is an aggregate of persons who hold themselves out as providers of emergency medical services who:
(a) do not routinely provide transportation to ill or injured persons; and
(b) routinely offer to provide services to the general public beyond the boundaries of a single recreational site, work site, school or other facility.
(2) A nontransporting EMS service must have an agreement with a licensed ambulance service to ensure continuity of care

and adequate transportation for its patients. An ambulance service is not required to approve of or enter into an agreement with a nontransporting EMS service.

(3) A law enforcement agency, fire department, search and rescue unit, ski patrol or mine rescue unit which does not hold itself out as a provider of emergency medical care to the public shall not be considered a nontransporting service solely because members of that unit or department provide medical care at the scene of a medical emergency to which they were dispatched for other purposes.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

RULE IV SAFETY AND EXTRICATION KIT (1) A safety and extrication kit must include the following equipment and supplies:

(a) a total of five pounds of ABC fire extinguisher, except for an extinguisher in an air ambulance, which must meet FAA standards;

(b) one short immobilization device with patient securing materials;

(c) three rigid cervical collars of assorted sizes;

(d) one phillips screwdriver;

(e) one straight blade screwdriver;

(f) one spring loaded center punch;

(g) one crescent wrench;

(h) one pair pliers; and

(i) one hacksaw and blade.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

RULE V TRANSPORTATION EQUIPMENT KIT (1) A transportation and equipment kit must include the following equipment and supplies:

(a) one suction unit, either portable or permanently installed, which operates either electrically or by engine vacuum and includes all necessary operating accessories;

(b) an oxygen supply administration system containing a minimum of 1,000 liters of oxygen;

(c) one sterile disposable humidifier;

(d) one rigid pharyngeal suction tip;

(e) one long spinal immobilization device with patient securing materials;

(f) one lower extremity traction device;

(g) two lower extremity rigid splints;

(h) two upper extremity rigid splints;

(i) one ambulance cot with at least two restraining straps and, with the exception of an air ambulance litter, four wheels and the capability of elevating the head; and

(j) clean linen for the primary cot and for replacement.

AUTH: Sec. 50-6-323, MCA

IMP: Sec. 50-6-323, MCA

RULE VI LICENSE RENEWALS (1) License renewals will be for two year periods and will expire on December 31 of the second year of the period.

AUTH: 50-6-323, MCA
IMP: 50-6-323, MCA

RULE VII ADVERTISING RESTRICTIONS (1) Except as otherwise specifically provided in this chapter, no person may:

(a) advertise the provision of an emergency medical service without first having obtained a license from the department; or

(b) advertise, allow advertisement of, or otherwise imply provision of emergency medical services at a level of care higher than that for which the service is licensed.

AUTH: 50-6-323, MCA
IMP: 50-6-323, MCA

RULE VIII STANDARD OF CARE (1) All emergency medical personnel must provide care which conforms to the general standard of care expected of persons who are comparably trained, certified or licensed.

AUTH: 50-6-323, MCA
IMP: 50-6-323, MCA

RULE IX EMT LEVEL OF CARE LIMITATIONS (1) With the exception of a physician or the circumstances described in ARM 37.104.335(3), no attempt may be made by personnel to provide a level of care higher than the level and type for which the emergency medical service is licensed, even though individual members of the emergency medical services may have a higher level of certification.

(2) An EMT licensed or endorsed beyond the EMT-B level may perform acts allowed under the EMT's licensure level or endorsement level only when authorized under the service license.

AUTH: 50-6-323, MCA
IMP: 50-6-323, MCA

RULE X SERVICE OPERATION (1) An emergency medical service may not be operated in a manner that presents a risk to, threatens, or endangers the public health, safety, or welfare.

AUTH: 50-6-323, MCA
IMP: 50-6-323, MCA

RULE XI AUTHORIZATION (1) In order for a basic service to be authorized at a higher level of service, it must:

(a) apply on forms provided by the department; and

(b) have an approved service medical director.

AUTH: 50-6-323, MCA
IMP: 50-6-323, MCA

3. The rules as proposed to be amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.104.101 DEFINITIONS The following definitions apply in subchapters 1 through 4.

(1) "Advanced life support (ALS)" means an advanced life support provider as defined in ARM 24.156.2701.

~~(1)~~ (2) "Advanced life support service" means an ~~emergency medical service which~~ ambulance service or nontransporting medical unit that has the capacity and is licensed by the department to provide care at ~~the EMT-paramedic equivalent level.~~ any of the following levels of care or endorsements 24 hours a day, seven days a week:

(a) EMT-B 1, EMT-B 3, EMT-B 4, and EMT-B 5 endorsements;

(b) EMT-I and all EMT-I endorsements; or

(c) EMT-P and all EMT-P endorsements.

~~(2)~~ (3) "Advanced life support (ALS) kit" means ~~all of the following~~ equipment and supplies~~:~~ necessary to support the level of care and endorsements authorized by the service medical director.

~~(a) an EMT-intermediate kit, with the exception that the monitor/defibrillator must have a self contained monitor, ECG strip writer, and quick look paddles;~~

~~(b) five each of three assorted sizes of needles;~~

~~(c) two each of three assorted sizes of syringes;~~

~~(d) medications consistent with the level of service and as identified in protocols.~~

~~(3)~~ (4) "Advisory committee" means the department advisory committee specified in 50-6-324, MCA.

~~(4)~~ (5) "Ambulance service" means an emergency medical service that utilizes an ambulance.

(6) "Authorization" means department approval of an ambulance service or nontransporting medical unit (NTU) to provide advanced life support on a less than 24 hours per day, seven day per week basis due to limited personnel.

~~(5)~~ (7) "Automated external defibrillator (AED)" means a medical device heart monitor and defibrillator~~, with an event recorder,~~ that is approved by the ~~department and that:~~ U.S. food and drug administration.

~~(a) is capable of recognizing the presence or absence of ventricular fibrillation and rapid ventricular tachycardia and of determining whether defibrillation should be performed; and~~

~~(b) whenever it determines that defibrillation should be performed, charges and delivers an electrical impulse at the command of the operator.~~

~~(6)~~ (8) "Basic equipment kit" means ~~all of the following equipment and supplies:~~ the equipment and supplies required by [Rule I].

~~(a) two air occlusive dressings;~~

~~(b) one blood pressure manometer with adult, extra large~~

~~adult, and pediatric cuffs;~~

~~(c) one stethoscope;~~

~~(d) five dressings (assorted);~~

~~(e) two pairs of exam gloves;~~

~~(f) one pair of safety glasses to provide splash protection for the emergency care provider;~~

~~(g) one surgical mask;~~

~~(h) one oral glucose;~~

~~(i) one flashlight;~~

~~(j) four soft roller bandages;~~

~~(k) four rolls of adhesive tape of assorted sizes;~~

~~(l) four triangular bandages;~~

~~(m) four oropharyngeal airways of assorted child and adult sizes;~~

~~(n) one mouth to mask resuscitator with one-way valve, oxygen inlet and oxygen connecting tubing;~~

~~(o) one bulb syringe or equivalent suction apparatus;~~

~~(p) one portable oxygen system containing at least 200 liters of oxygen and with regulator and flowmeter;~~

~~(q) one adult and one pediatric oxygen mask;~~

~~(r) one nasal oxygen cannula;~~

~~(s) one pair of scissors;~~

~~(t) one pair of heavy leather gloves;~~

~~(u) one helmet for personnel that is capable of protection from head injury;~~

~~(v) paper and pen or pencil.~~

(9) "Basic life support (BLS)" means a basic life support level of care as defined in ARM 24.156.2701.

~~(7)~~ (10) "Basic life support service" means an ~~emergency medical service~~ ambulance service or nontransporting medical unit capable of providing care at the basic life support level and licensed as a provider under [Rule II].

(11) "Board" means the Montana board of medical examiners of the department of labor and industry, more commonly referred to as BME or BOME.

~~(8)~~ (12) "Defibrillator with dual channel recording capabilities" means a device, approved by the department, capable of continuously recording the electrocardiogram and simultaneously recording the events at the scene, and shall be portable, self-contained, DC powered, and capable of defibrillation according to the defibrillation protocol, either manually, semi-automatically or automatically.

~~(9) "Defibrillation protocol" means a uniform protocol for an EMT-defibrillation equivalent or EMT-intermediate equivalent functioning within an emergency medical service, adopted by the Montana board of medical examiners for statewide use, specific to the type of defibrillator being used, and signed by the off-line medical director.~~

~~(10)~~ (13) "Emergency medical technician-basic (EMT-B)" ~~(EMT-basic)~~ means an individual who is licensed by the board as an EMT-B. ~~certified as an EMT-basic by the Montana board of medical examiners.~~

~~(11)~~ (14) "Emergency medical technician-basic (EMT-basic) equivalent" means one of the following:

~~(a) from January 1, 1990, through December 31, 1992, one of the following:~~

~~(i) EMT-basic;~~

~~(ii) EMT-defibrillation;~~

~~(iii) EMT-intermediate;~~

~~(iv) EMT-paramedic;~~

~~(v) registered nurse;~~

~~(b) from January 1, 1993, on, one of the following:~~

~~(i) EMT-basic;~~

~~(ii) EMT-defibrillation;~~

~~(iii) EMT-intermediate;~~

~~(iv) EMT-paramedic;~~

~~(v) grandfathered nurse;~~

~~(vi) registered nurse with supplemental training.~~

(a) an EMT-basic;

(b) any licensed EMT provider above EMT-B, including endorsements; or

(c) a registered nurse with supplemental training.

~~(12) "Emergency medical technician-defibrillation (EMT-defibrillation)" means a person certified as an emergency medical technician-defibrillation by the Montana board of medical examiners.~~

~~(13) "Emergency medical technician-defibrillation (EMT-defibrillation) equivalent" means:~~

~~(a) from January 1, 1990, through December 31, 1992, one of the following:~~

~~(i) EMT-defibrillation;~~

~~(ii) EMT-intermediate;~~

~~(iii) EMT-paramedic;~~

~~(iv) registered nurse who has written authorization from the off-line medical director to perform defibrillation according to protocol;~~

~~(b) after January 1, 1993, one of the following:~~

~~(i) EMT-basic who has successfully completed either an EMT-basic transition course approved by the department or an EMT-basic course following the United States department of transportation's 1994 national standard curriculum, which is adopted by reference as noted in (42) below;~~

~~(ii) EMT-defibrillation;~~

~~(iii) EMT-intermediate;~~

~~(iv) EMT-paramedic;~~

~~(v) grandfathered nurse;~~

~~(vi) registered nurse with supplemental training.~~

(15) "Emergency medical technician-first responder (EMT-F)" means an individual who is licensed by the board as an EMT-F.

(16) "Emergency medical technician-first responder equivalent" means one of the following:

(a) an EMT-F;

(b) any licensed EMT provider above EMT-F, including endorsements; or

(c) a registered nurse with supplemental training.

~~(14)~~ (17) "Emergency medical technician-intermediate (EMT-I)" means an individual who is licensed by the board as an EMT-I. ~~(EMT-intermediate)" means a person certified as an emergency~~

~~medical technician-intermediate by the Montana board of medical examiners.~~

~~(15)~~ (18) "Emergency medical technician-intermediate ~~(EMT-intermediate)~~ (EMT-I) equivalent" means one of the following:

~~(a) from January 1, 1990, through December 31, 1992, one of the following:~~

~~(i) EMT-intermediate;~~

~~(ii) EMT-paramedic;~~

~~(iii) registered nurse who has written authorization from the off-line medical director to perform at the EMT-intermediate level;~~

~~(b) from January 1, 1993, on, one of the following:~~

~~(i) EMT-intermediate;~~

~~(ii) EMT-paramedic;~~

~~(iii) grandfathered nurse;~~

~~(iv) registered nurse with supplemental training.~~

(a) an EMT-intermediate;

(b) any licensed EMT provider above EMT-I, including endorsements; or

(c) a registered nurse with supplemental training.

~~(16)~~ (19) "Emergency medical technician-paramedic (EMT-P)" means an individual who is licensed by the board as an EMT-P. ~~(EMT-paramedic)" means a person certified as an emergency medical technician-paramedic by the Montana board of medical examiners.~~

~~(17)~~ (20) "Emergency medical technician-paramedic ~~(EMT-paramedic)~~ (EMT-P) equivalent" means one of the following:

~~(a) from January 1, 1990, through December 31, 1992, one of the following:~~

~~(i) EMT-paramedic;~~

~~(ii) registered nurse who has written authorization from the off-line medical director to perform at the EMT-paramedic level;~~

~~(b) from January 1, 1993, on, one of the following:~~

~~(i) EMT-paramedic;~~

~~(ii) grandfathered nurse;~~

~~(iii) registered nurse with supplemental training.~~

(a) an EMT-paramedic;

(b) an EMT provider with an endorsement above EMT-P; or

(c) a registered nurse with supplemental training.

~~(18) "EMT-defibrillation life support service" means an emergency medical service capable of providing care at the EMT-defibrillation equivalent level.~~

~~(19) "EMT-D defibrillation kit" means the following equipment and supplies:~~

~~(a) one defibrillator with dual channel recording capabilities or an automated external defibrillator;~~

~~(b) electrodes sufficient for two patients; and~~

~~(c) a patient cable.~~

~~(20) "EMT-intermediate kit" means all of the following equipment and supplies:~~

~~(a) a total of 1000 cc's of dextrose, 5% in water;~~

~~(b) a total of 2000 cc's of lactated Ringers solution;~~

~~(c) a total of 1000 cc's of normal saline IV solution;~~

~~(d) one intravenous administration set, minidrip;~~

~~(e) two intravenous administration sets, standard;~~

~~(f) three each of four different gauge, catheter over the needle, sets;~~

~~(g) two IV tourniquets;~~

~~(h) one esophageal obturator airway;~~

~~(i) one adult pneumatic anti-shock garment;~~

~~(j) alcohol and betadine swabs;~~

~~(k) two sets of four different sized endotracheal tubes;~~

~~(l) one laryngoscope handle and two blades;~~

~~(m) the EMT-D defibrillation kit.~~

~~(21) "EMT-intermediate life support service" means an emergency medical service which is capable of providing care at the EMT-intermediate equivalent level.~~

~~(22)~~ (21) "FAA" means the federal aviation administration.

~~(23) "First responder" means a person who has first responder status by virtue of complying with department guidelines for attaining such status.~~

~~(24)~~ (22) "First responder-ambulance" means an individual licensed by the board as an EMT-F with an ambulance endorsement as listed in ARM 24.156.2751. ~~a person who has first responder-ambulance status by virtue of complying with department guidelines for attaining such status.~~

~~(25)~~ (23) "Grandfathered advanced first aid" means a person:

~~(a) from January 1, 1990, through December 31, 1992, a person certified in:~~

~~(i) American red cross advanced first aid and emergency care; and~~

~~(ii) cardiopulmonary resuscitation according to current American heart association standards; and~~

~~(b) on or after January 1, 1993, a person:~~

~~(i) certified in American red cross advanced first aid and emergency care;~~

~~(ii) certified in cardiopulmonary resuscitation according to current American heart association standards; and~~

~~(iii) who was continuously a member of a licensed emergency medical service from July 1, 1992, through December 31, 1992.~~

(a) certified in American red cross emergency response;

(b) certified in cardiopulmonary resuscitation according to current American heart association standards; and

(c) who was continuously a member of a licensed emergency medical service and was certified in American red cross advanced first aid and emergency care from July 1, 1992 through December 31, 1992.

~~(26) "Grandfathered nurse" means a registered nurse who is continuously a member of a licensed emergency medical service from July 1, 1992, through December 31, 1992, and who may provide services up to a level equal to the highest level of service they provided during the period from July 1 through December 31, 1992.~~

~~(27)~~ (24) "Level of service" means either basic life support~~, EMT-defibrillation life support, EMT-intermediate life support,~~ or advanced life support services.

~~(28) "Medical control" means the provision of direction, advice, and/or orders by a physician to personnel of an emergency~~

~~medical service. Medical control includes:~~

~~(a) "On-line medical control", which means the provision of medical direction, advice, and/or orders to emergency care providers while on a call and functioning with a licensed EMT-defibrillation, EMT-intermediate, or advanced life support service. On-line medical control is supervised by the off-line medical director.~~

~~(b) "Off-line medical control", which means the provision of overall medical direction and advice to an emergency medical service.~~

~~(29)~~ (25) "Non-transporting medical unit (NTU)" means a nontransporting unit as specified in [Rule III]. ~~an aggregate of persons who are organized to respond to a call for emergency medical services and to treat a patient until the arrival of an ambulance. A non-transporting medical unit:~~

~~(a) consists of more than a single individual;~~

~~(b) provides coverage and response, as a group, to a defined geographic area;~~

~~(c) is organized, as a group, to provide a medical response to emergencies as one of its primary objectives;~~

~~(d) is routinely dispatched to emergency medical calls; and~~

~~(e) offers to provide a medical response to other organizations or the public.~~

~~(30) "Off-line medical director" means a physician who:~~

~~(a) is responsible and accountable for the overall medical direction and medical supervision of an emergency medical service at the EMT-defibrillation, EMT-intermediate, or advanced life support level;~~

~~(b) is responsible for the proper application of patient care techniques and the quality of care provided by the emergency medical services personnel at the EMT-defibrillation, EMT-intermediate, or advanced life support level;~~

~~(c) has been approved in writing by a local hospital medical staff and/or department of emergency medicine, if one exists, or, if there is no hospital in the community, by the medical staff and/or department of emergency medicine of a hospital in a nearby community to which patients are most commonly transported; and~~

~~(d) approves all protocols for use by emergency medical services personnel functioning in an EMT-defibrillation, EMT-intermediate, or advanced life support service.~~

(26) "Online medical direction" means online medical direction as defined in ARM 24.156.2701.

~~(31)~~ (27) "Permit" means ~~the sticker affixed to a ground ambulance or~~ a certificate placed in an air or ground ambulance indicating the ambulance vehicle has met the requirements of these rules.

~~(32) "Protocol" means a set of written, standardized guidelines for administering patient care, at an EMT-intermediate or advanced life support level, and approved by the department and by the off-line medical director.~~

(28) "Statewide protocol" means the statewide protocols defined in ARM 24.156.2701.

~~(33)~~ (29) "Provisional license" means an emergency medical

service license which is granted by the department and is valid for a maximum of 90 days.

~~(34)~~ (30) "Safety and extrication equipment kit" means the ~~following~~ equipment and supplies~~:~~ required in [Rule IV].

~~(a) a total of 5 pounds of ABC fire extinguisher, except for an extinguisher in an air ambulance, which must meet FAA standards;~~

~~(b) one short immobilization device with patient securing materials;~~

~~(c) three rigid cervical collars of assorted sizes;~~

~~(d) one phillips screwdriver;~~

~~(e) one straight blade screwdriver;~~

~~(f) one spring loaded center punch;~~

~~(g) one crescent wrench;~~

~~(h) one pair pliers;~~

~~(i) one hacksaw and blade.~~

(31) "Service medical director" means a person who meets the requirements of a service medical director as provided in ARM 24.156.2701.

(32) "Service plan" means a written description of how an ambulance service or NTU service plans to provide response within its normal service area.

~~(35)~~ (33) "Stipulations" mean those conditions specified by the department at the time of licensing which must be met by the applicant in order to be licensed as an emergency medical service.

~~(36)~~ (34) "Supplemental training" means a training program for registered nurses utilized by an emergency medical service ~~which:~~ that

~~(a)~~ complements their existing education and results in knowledge and skill objectives comparable to the level of EMT training corresponding to the ~~level at which the service is licensed; and~~ license level authorized by the service medical director.

~~(b) is certified by the emergency medical service's medical director as having knowledge and skill objectives comparable to the level of EMT training corresponding to the level at which the service is licensed.~~

~~(37) "Surrogate" means a registered nurse, licensed in Montana, who:~~

~~(a) relays medical control orders consistent with the protocols established for a licensed EMT-intermediate life support service;~~

~~(b) is capable of demonstrating all of the skills required for the EMT-intermediate level;~~

~~(c) is approved by and is responsible to the off-line medical director.~~

~~(38)~~ (35) "Temporary permit" means a written authorization of limited duration indicating an ambulance vehicle may be used by a licensed ambulance service until a permit can be issued.

~~(39) "Temporary work permit" means a written authorization granted by the Montana board of medical examiners for a person who is eligible to take a Montana EMT certification exam to function as an EMT until the results of their examination are~~

~~known.~~

~~(40)~~ (36) "Transportation equipment kit" means the ~~following~~ equipment and supplies required in [Rule V].~~:~~

~~(a) one suction unit, either portable or permanently installed, which operates either electrically or by engine vacuum and includes all necessary operating accessories;~~

~~(b) an oxygen supply administration system containing a minimum of 1000 liters of oxygen;~~

~~(c) one sterile disposable humidifier;~~

~~(d) one rigid pharyngeal suction tip;~~

~~(e) one long spinal immobilization device with patient securing materials;~~

~~(f) one lower extremity traction device;~~

~~(g) two lower extremity rigid splints;~~

~~(h) two upper extremity rigid splints;~~

~~(i) one ambulance cot with at least two restraining straps and, with the exception of an air ambulance litter, four wheels and the capability of elevating the head; and~~

~~(j) clean linen for the primary cot and for replacement.~~

~~(41)~~ (37) "Type of service" means either an air ambulance fixed wing, air ambulance–rotor wing, ground ambulance~~–ground~~, or non–transporting medical unit.

~~(42) The department hereby adopts and incorporates by reference the U.S. department of transportation's Emergency Medical Technician: Basic National Standard Curriculum (1994), developed pursuant to contract number DTNH22-90-C-05189, which contains a national standard training program for EMT-basics. A copy of the curriculum may be obtained from the Department of Public Health and Human Services, Health Policy Services Division, Emergency Medical Services and Injury Prevention Section, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951, telephone: (406)444-3895.~~

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.105 LICENSE TYPES AND LEVELS (1) A license will be issued for, and authorize performance of, emergency medical services of a specific type and at a ~~specific~~ basic or advanced life support level.

(2) ~~Each type of service may be licensed at any level.~~ Except as specifically provided in this chapter, an emergency medical service may be licensed at an advanced life support level only if they can reasonably provide such service 24 hours a day, seven days a week.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-306 and 50-6-323, MCA

37.104.106 LICENSE APPLICATION REQUIREMENTS (1) An application for a license to conduct an emergency medical service, including the renewal of a license, must be made on forms specified by the department, accompanied by the license fee, and~~, with the exceptions noted in (b) and (c) below,~~

received by the department~~:~~

~~(a)~~ not less than 30 days prior to the commencement of a new emergency medical service or the expiration of the license~~,~~ in the case of an application for renewal~~;~~.

~~(b) for licenses to commence January 1, 1990, by December 31, 1989; and~~

~~(c) in the case of non-transporting medical units, rotor wing air ambulance services, and fixed wing air ambulance services existing on January 1, 1990, by March 30, 1990.~~

(2) ~~Except for the period of January 1, 1990, to June 30, 1990, within~~ Within 30 days from receipt of an emergency medical service license application or, if the department requests additional information about the application, within 30 days from receipt of that information, the department shall ~~either~~:

(a) issue the license;

(b) issue the license with stipulations;

(c) issue a provisional license; or

(d) deny the license.

(3) The department may deny an emergency medical services license if:

(a) the application does not provide all of the requested information; or

(b) there is evidence that the applicant is not complying with these rules.

(4) ~~Except for the period of January 1, 1990, through June 30, 1990, if~~ If the department does not take action on the application within 30 days after its receipt, the emergency medical services license must be issued unless the applicant is known to be in violation of these rules.

(5) ~~Except for the year beginning January 1, 1990, the~~ The department shall inspect each emergency medical service prior to issuing a license. If an inspection cannot be conducted, the department may issue a provisional license until an inspection can be completed.

(6) To establish staggered terms of licensing:

~~(a) Every emergency medical service that submits a completed license application to the department before or during 1990 will be assigned a number in the chronological order its application is received by the department, an odd-numbered service will receive a license expiring December 31, 1990, and an even-numbered service will receive a license expiring December 31, 1991;~~

~~(b)~~ (a) When the department receives a completed license application for a new emergency medical service ~~after December 31, 1990~~, it will assign that service a number ~~in the manner described in (a) above,~~; and

(b) if it grants the license:

(i) an odd-numbered service will be issued a license expiring December 31 of the year in which it was issued; and

(ii) an even-numbered service will be issued a license expiring December 31 of the year following the year in which it was issued.

~~(c) License renewals will be for 2-year periods, and will expire on December 31 of the 2nd year of the period.~~

~~(7) No person may:~~

~~(a) advertise the provision of an emergency medical service without first having obtained a license from the department; or~~

~~(b) advertise, allow advertisement of, or otherwise imply provision of emergency medical services at a level of care higher than that for which the service is licensed.~~

~~(8)~~ (7) If an emergency medical service from another state identifies Montana as part of its service area, and if it regularly provides an initial emergency medical services response into Montana, the emergency medical service must obtain a Montana emergency medical services license as provided by these rules, unless the other state's licensing standards are essentially comparable to those of Montana, in which case the department may license these services through a reciprocal agreement with the other state.

~~(9)~~ (8) An emergency medical service responding into Montana to transfer patients from a Montana medical facility to a non-Montana medical facility is not required to obtain a Montana license if it is licensed in its state of origin.

~~(10)~~ (9) If a licensed emergency medical service is not reasonably available, the occasional and infrequent transportation by other means is not prohibited.

~~(11)~~ (10) In a ~~major~~ catastrophe or major emergency when licensed ambulances are insufficient to render services required, non-licensed emergency medical services may be used.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-306, 50-6-313 and 50-6-323, MCA

37.104.201 COMMUNICATIONS ~~(1) A ground ambulance must have a VHF mobile radio, and an air ambulance have a VHF portable radio with a minimum of frequency 155.280 mHz.~~

~~(2) Effective January 1, 1996:~~

~~(a)~~ (1) ~~a~~ A ground ambulance must have a VHF mobile radio, and an air ambulance must have a VHF portable radio, each with a minimum of the following:

~~(i)~~ (a) dual tone multi-frequency encoder;

~~(ii)~~ (b) frequency 155.280 mHz;

~~(iii)~~ (c) frequency 155.340 mHz;

~~(iv)~~ (d) frequency 155.325 mHz;

~~(v)~~ (e) frequency 155.385 mHz; and

~~(vi)~~ (f) frequency 153.905 mHz.

~~(b)~~ (2) ~~a~~A non-transporting unit must have the capability of providing at least one radio at every emergency medical scene with a minimum of the following:

~~(i)~~ (a) frequency 155.280 mHz;

~~(ii)~~ (b) frequency 155.340 mHz; and

~~(iii)~~ (c) frequency 153.905 mHz.

(3) An emergency medical service must have current legal authorization to use each of the frequencies required ~~above~~ in (2).

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.203 EQUIPMENT (1) A basic equipment kit must be in each ground ambulance and available to each non-transporting unit and air ambulance on every call.

(2) When table I ~~below~~ in (6) shows that a transportation equipment kit or safety and extrication kit is required, it must be physically in each ground ambulance at all times and available to each air ambulance on every call.

(3) ~~Neither an EMT-D defibrillation kit, an EMT-intermediate kit, nor an~~ An advanced life support kit ~~need~~ does not need to be permanently stored on or in an ambulance or non-transporting unit, but may be kept separately in a modular, pre-packaged form, so long as it is available for rapid loading and easy access at the time of an emergency response.

~~(4) If table I below shows that an EMT-intermediate kit or an advanced life support kit is required, but the off-line medical director notifies the department in writing that an item of equipment or supplies in the relevant kit will not be used in the emergency medical service, that item will not be required for licensure and the service may not use that item when providing emergency care.~~

~~(5)~~ (4) Table I ~~below~~ in (6) shows the equipment kit which is required for licensure at each of the various types and levels of emergency medical services~~:~~.

(5) For the purpose of Table I in (6), the following terms apply:

(a) ~~[~~basic~~=~~ means basic equipment kit;

(b) transport~~=~~ means transportation equipment kit;

(c) safety~~=~~ means safety and extrication kit~~; EMT-D=EMT-D defibrillation kit; EMT-I=EMT-intermediate kit~~; and

(d) ALS~~=~~ means advanced life support kit~~]~~.

(6) TABLE I

Equipment kit

	Basic	Trans-port	Safety	~~EMT-D~~	~~EMT-I~~	ALS
Non-transport-basic	X					
~~Non-transport-defib~~	~~X~~			~~X~~		
~~Non-transport-interm.~~	~~X~~				~~X~~	
Non-transport-ALS	X					X
Ambulance-basic	X	X	X			
~~Ambulance-defib~~	~~X~~	~~X~~	~~X~~	~~X~~		
~~Ambulance-intermed.~~	~~X~~	~~X~~	~~X~~		~~X~~	
Ambulance-ALS	X	X	X			X
Air (rotor)-basic	X	X	X			

~~Air (rotor)-defib~~	~~X~~	~~X~~	~~X~~	~~X~~		
~~Air (rotor)-interm.~~	~~X~~	~~X~~	~~X~~		~~X~~	
Air (rotor)-ALS	X	X	X			X
Air (fixed)-basic	X	X				
~~Air (fixed)-defib~~	~~X~~	~~X~~		~~X~~		
~~Air (fixed)-interm.~~	~~X~~	~~X~~			~~X~~	
Air (fixed)-ALS	X	X				X

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.208 SANITATION (1) Each emergency medical service must develop and adhere to a written service sanitation policy that includes at least a method to dispose of contaminated materials meeting the minimum requirements set out in (2) ~~below~~, as well as the following standards:

(a) Products for cleaning shall contain a recognized, effective germicidal agent;

(b) Disposable equipment must be disposed of after its use;

(c) Any equipment that has come in contact with body fluids or secretions must be cleaned with a recognized germicidal/viricidal product;

(d) Linen must be changed after every use;

(e) Oxygen humidifiers must be single service and disposable; and

(f) Needles must not be recapped, bent, or broken, and must be disposed of in a container that provides protection to personnel from a needle puncture.

(2) Each emergency medical service must do at least the following in disposing of ~~infective~~ infectious waste:

(a) ~~Either incinerate the waste or decontaminate it before disposing of it in a sanitary landfill licensed for that class of waste by the department;~~ each service shall store, transport off the premises, and dispose of infectious waste as defined in 75-10-1003, MCA and in accordance with the requirements set forth in 75-10-1005, MCA; and

(b) ~~Place sharp items in puncture-proof containers and other blood-contaminated items in leak-proof plastic bags for transport to a landfill licensed by the department for that class of waste.~~ used sharps shall be properly packaged and labeled as provided in 75-10-1005, MCA, and as required by the occupational safety and health administration (OSHA).

(3) The interior of an ambulance, including all storage areas, must be kept clean and free from dirt, grease and other offensive matter.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.212 RECORDS AND REPORTS (1) Each emergency medical service must maintain a trip report for every run in which patient care was offered or provided, which contains at least the following information:

(a) identification of the emergency medical services provider;

(b) date of the call;

(c) patient's name and address;

(d) type of run;

(e) identification of all emergency medical services providers, riders, trainees, or service personnel officially responding to the call;

(f) the time:

(i) the dispatcher was notified;

(ii) the emergency medical service was notified;

(iii) the emergency medical service was enroute;

(iv) of arrival on the scene;

(v) the service departed the scene or turned over the patient to an ambulance service; and

(vi) of arrival at receiving hospital, if applicable;

(g) history of the patient's illness or injury, including the findings of the physical examination;

(h) treatment provided or offered by the emergency medical services personnel, including, when appropriate, a record of all medication administered, the dose, and the time administered;

(i) record of the patient's vital signs, including the time taken, if applicable;

(j) utilization of on-line medical control, if applicable; and

(k) destination of the patient, if applicable.

(2) Trip reports may be reviewed by the department.

(3) Copies of trip reports must be maintained by the service for a minimum of ~~7~~ seven years.

(4) Each emergency medical service must provide the department with a quarterly report, on a form provided by the department, that specifies the number and types of runs occurring during the quarter, the type of emergency, and the average response times.

~~(5) In addition to the requirements in (1)(a) through (i) above, any type of service functioning at the EMT-defibrillation level or the EMT-intermediate level must assure that their medical director reviews every run necessitating use of a defibrillator.~~

~~(6)~~ (5) As soon as ~~practicable,~~ possible, but no later than 48 hours after the end of the patient transport, an ambulance service must provide a copy of the trip report to the hospital that receives the patient.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.213 PERSONNEL REQUIREMENTS~~: GENERAL~~ (1) Each emergency medical service must meet the following personnel standards:

(a) All personnel functioning on the emergency medical service must have current certificates, licenses, proof of training or evidence of legal authorization to function~~, or a temporary work permit for a given level of certification or licensure~~;

~~(b) All emergency medical personnel must provide care which conforms to the general standard of care expected of persons who are comparably trained, certified, or licensed;~~

~~(c)~~ (b) Emergency medical services personnel may use only that equipment and perform those skills for which they are trained, certified, or licensed and legally permitted to use;

~~(d)~~ (c) ~~Advanced first aid and emergency care personnel may use oxygen and suction but not pneumatic anti-shock trousers;~~ When functioning under the conditions defined in ARM 24.156.2771, a licensed service may use EMTs licensed in another state to provide basic life support; and

(d) EMTs on licensed services may carry and administer auto-injectors as provided for in ARM 24.156.2771.

~~(e) With the exception of a physician or the circumstances described in ARM 37.104.335(3), no attempt may be made by personnel to provide a level of care higher than the level and type for which the emergency medical service is licensed, even though individual members of the emergency medical services may have a higher level of certification; and~~

~~(f) The emergency medical service is not operated in a manner which presents a risk to, threatens, or endangers the public health, safety, or welfare.~~

~~(2) With the exception of a physician or the circumstances described in ARM 37.104.335(3), an individual with a level of certification higher than the level of service license may function only to the level of the service license.~~

~~(3) An EMT-defibrillation equivalent may perform under a defibrillation protocol only if acting under the authority of a licensed EMT-defibrillation life support, EMT-intermediate life support, or advanced life support service.~~

~~(4)~~ (2) All ambulances must have at least one of the required personnel as set forth in ARM 37.104.316, 37.104.319, 37.104.326, 37.104.329, 37.104.401, and 37.104.404 attending the patient, and, when providing care at an ~~EMT-defibrillation, EMT-intermediate, or~~ advanced life support level, the person certified at the corresponding level must attend the patient.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.218 MEDICAL CONTROL: ~~GENERAL~~ SERVICE MEDICAL DIRECTOR (1) Each emergency medical service ~~at~~ that provides service at the ~~EMT-defibrillation, EMT-intermediate, or~~ advanced life support level shall have a service medical director.~~:~~

(2) The requirements and responsibilities of the service

medical director shall be as defined in ARM 24.156.2701.

~~(a) an off-line medical director;~~

~~(b) a written plan, approved by the department, for on-line medical control;~~

~~(c) protocols consistent with the level of service and approved by the department; and~~

~~(d) written procedures for the security and replacement of all medications.~~

~~(2) Each emergency medical service must supply each hospital to which it commonly transports patients with copies of all protocols that it adopts.~~

(3) As provided in ARM 24.156.2701, a designated service medical director must be a physician or physician assistant-certified who is responsible professionally and legally for overall medical care provided by a licensed ambulance service.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.221 MEDICAL CONTROL: ADVANCED LIFE SUPPORT

(1) An advanced life support service must have ~~either:~~

~~(a)~~ a two-way communications system, approved by the department, between the advanced life support service personnel and a 24-hour physician–staffed emergency department or with a physician approved by the service medical director.~~; or~~

~~(b) if two-way communications from the field cannot be established with a 24-hour physician-staffed emergency department, medical control of the advanced life support personnel through an approved communications system with either:~~

~~(i) a hospital emergency department (physician only); or~~

~~(ii) a physician approved by the medical director.~~

(2) A service that provides only endorsement level EMT-B 2 as provided for in ARM 24.156.2751 is not required to have online medical direction.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.306 AMBULANCE SPECIFICATIONS: GROUND AMBULANCES

(1) ~~By January 1, 1993, all~~ All ground ambulances must have the following markings and emblems:

(a) The word "ambulance" must be affixed in mirror image in reflectorized lettering, centered above the grill on the front of the vehicle; and

(b) The word "ambulance" must be affixed to the rear of the vehicle in reflectorized lettering.

(2) The required markings may not appear on non–licensed ambulances, with the exception of those ambulances temporarily in transit within the state.

(3) An ambulance must be equipped with operational emergency lighting and siren.

(4) All new ambulances, except those in service in Montana on or before January 1, 1990, must be equipped with audible backup warning devices.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.307 AMBULANCE SPECIFICATIONS: AIR AMBULANCE

(1) A rotor wing air ambulance must be fitted with an FAA-approved, externally mounted~~,~~ searchlight of at least 300,000 candle power, capable of being controlled by the pilot without removing his hands from the flight controls, with a minimum motion of 90 degrees vertical and 180 degrees horizontal.

(2) The stretcher for the air ambulance must be secured by an FAA-approved method and must meet FAA static test load factors ~~as specified in 14 CFR 43.13(b)~~.

(3) The entrance in an ambulance for patient loading must be constructed so that under normal circumstances the stretcher does not require excessive tilting or rotation around the pitch or roll axis.

~~(4) The department hereby adopts and incorporates by reference 14 CFR 43.13(b), containing federal standards for air ambulance stretchers. A copy of 14 CFR 43.13(b) may be obtained from the Department of Public Health and Human Services, Health Policy Services Division, Emergency Medical Services and Injury Prevention Section, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951; or from the Federal Aviation Administration, Helena, MT 59601, telephone: (406)449-5290.~~

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.311 SAFETY: GROUND AMBULANCE SERVICES (1) ~~An~~ Except as provided in (3), an emergency medical service must take measures to assure that the carbon monoxide level in a ground ambulance does not exceed 10 parts per million accumulation at the head of the patient stretcher.~~, including the following:~~

~~(a)~~ The service must continuously maintain~~ing~~ in the patient compartment:

(a) a disposable carbon monoxide detector, approved by the department, which is capable of immediately detecting a dangerous rise in the carbon monoxide level; or

(b) ~~writing on the detector the date of its placement, and replacing the detector prior to the expiration date;~~ an electronic carbon monoxide monitor.

~~(c) keeping replaced detectors for a period of 3 years.~~

(2) Services that use a disposable carbon monoxide detector must also:

(a) write on the detector the date of its placement; and

(b) keep replaced detectors for a period of three years.

(3) An emergency medical service is not required to maintain a carbon monoxide detector in a diesel powered ambulance.

~~(2)~~ (4) Windshields must be free from all cracks within the windshield wiper coverage area.

~~(3)~~ (5) Tires must have at least 4/32 inch of tread depth, measured at two points not less than 15 inches apart in any major

tread groove at or near the center of the tire.

~~(4)~~ (6) No one may smoke in a ground ambulance.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.312 SAFETY: AIR AMBULANCE (1) Each stretcher support must have, as a minimum, FAA-approved provisions for securing a 95th percentile adult American male patient, consisting of individual restraints across the chest and legs, and, with the exception of rotor—wing ambulances, a shoulder harness that meets FAA technical service order standards.

(2) In rotor—wing ambulances, high pressure containers and lines for medical gases may not be positioned in the scatter zone of the engine turbine wheels, unless adequate protection is provided to prevent penetration by turbine blade and wheel parts.

(3) Survival gear applicable to the needs of the area of operation and the number of occupants~~,~~ must be carried on board and appropriately maintained.

(4) Any modifications to the interior of an aircraft to accommodate medical equipment must have FAA approval and be maintained to FAA standards.

(5) No one may smoke in an air ambulance.

(6) An emergency medical service must take measures to assure that the carbon monoxide level does not exceed 10 parts per million accumulation at the head of the patient stretcher or in the pilot's compartment, including the following:

(a) continuously maintaining, in the patient compartment and in the pilot's compartment, disposable or electronic carbon monoxide detectors, approved by the department, which are capable of immediately detecting a dangerous rise in the carbon monoxide level;

(b) writing on each of the disposable detectors the date of its placement, and replacing it prior to the expiration date;

(c) keeping replaced disposable detectors for a period of ~~3~~ three years after the date of their replacement.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.316 PERSONNEL REQUIREMENTS: BASIC LIFE SUPPORT GROUND AMBULANCE SERVICE ~~(1) From January 1, 1990, through December 31, 1995, a basic life support ground ambulance service must ensure that at least two of the following individuals are on each call:~~

~~(a) grandfathered advanced first aid;~~

~~(b) first responder-ambulance;~~

~~(c) EMT-basic equivalent; or~~

~~(d) physician.~~

~~(2)~~ (1) ~~After January 1, 1996, a~~ A basic life support ground ambulance service must ensure that at least two of the following individuals are on ~~each call~~ board the ambulance when a patient is loaded or transported, with the proviso that having only two first responders-ambulance on a call is not allowed:

(a) grandfathered advanced first aid;
(b) first responder-ambulance;
(c) EMT-basic equivalent; or
(d) physician.

(2) A basic life support ambulance service may be authorized as provided in [Rule XI] to provide on some calls, based on personnel availability, a higher level of care than that for which it is licensed.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.319 PERSONNEL: ADVANCED LIFE SUPPORT GROUND AMBULANCE SERVICE (1) An advanced life support ground ambulance service must:

(a) meet the personnel requirements of a basic life support ground ambulance service contained in ARM 37.104.316; and

(b) when ~~responding~~ transporting a patient at the advanced life support level, ensure that one of the required personnel is an ~~EMT-paramedic equivalent~~ advanced life support EMT.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.329 PERSONNEL: ADVANCED LIFE SUPPORT AIR AMBULANCE SERVICE (1) In addition to the pilot, one ~~EMT-paramedic equivalent~~ advanced life support EMT is required.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.336 OTHER REQUIREMENTS: AIR AMBULANCE SERVICE

(1) An air ambulance service must be licensed under current ~~14 CFR Part 135 of the~~ FAA ~~rules~~ regulations.

~~(2) The department hereby adopts and incorporates by reference 14 CFR Part 135, which sets forth federal licensure requirements for air ambulance services. A copy of 14 CFR Part 135 may be obtained from the Department of Health and Human Services, Health Policy Services Division, Emergency Medical Services and Injury Prevention Section, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951; or from the Federal Aviation Administration, Helena, MT 59601, telephone: (406)449-5290.~~

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.401 PERSONNEL: BASIC LIFE SUPPORT NON-TRANSPORTING UNIT (1) ~~From January 1, 1990 on, at~~ At least one of the following individuals must be on each call:

(a) a person with a grandfathered advanced first aid training;
(b) ~~first responder~~ an EMT-first responder (EMT-F);
(c) an EMT-first responder ~~EMT-basic~~ equivalent; or
(d) a licensed physician.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.404 PERSONNEL: ADVANCED LIFE SUPPORT NON-TRANSPORTING UNIT (1) An advanced life support non-transporting unit must:

(a) meet the personnel requirements of a basic life support non-transporting unit contained in ARM 37.104.401; and

(b) when responding at the advanced life support level, ensure that at least one ~~EMT-paramedic equivalent~~ advanced level EMT is on the call.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

37.104.616 ~~PERFORMANCE~~ REQUIREMENTS OF AUTOMATED EXTERNAL DEFIBRILLATOR (AED) (1) An AED used by an AED program must be ~~capable of:~~ a unit approved by the U.S. food and drug administration.

~~(a) delivering a shock of a waveform that is either:~~

~~(i) damped sinusoidal; or~~

~~(ii) biphasic truncated exponential.~~

~~(b) delivering the shocks required by the AED program's authorized medical protocol; and~~

~~(c) operating satisfactorily in the environment in which it is intended to function.~~

AUTH: Sec. 50-6-503, MCA
IMP: Sec. 50-6-503, MCA

37.104.805 EXPOSURE FORM (1) A report of exposure must be filed with the health care facility by the designated officer on a form developed and approved by the department, entitled "Report of Exposure".

(2) The report form will require the following, at a minimum:

(a) name, address, and phone number~~(s)~~ of the emergency services provider who sustained an exposure;

(b) date and time of the exposure;

(c) a narrative description of the type of exposure that occurred, a detailed description of how the exposure took place, and a description of any precautions taken;

(d) the name and, if available, the date of birth of the patient;

(e) the name of the health care facility receiving the patient and the health care facility's infectious disease control officer;

(f) the name of the emergency services organization with which the health care provider was officially responding;

(g) the names and phone numbers of the designated officer and the alternate;

(h) the address of the designated officer to which the written notification required by 50-16-702(2)(c), MCA, is to be

sent; and

(i) the signature of the designated officer filing the report.

(3) A copy of the required form is available from the Department of Public Health and Human Services, ~~Health Policy and Services Division~~ Public Health and Safety Division, Emergency Medical Services and ~~Injury Prevention~~ Trauma Systems Section, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951, telephone: (406)444-3895.

(4) An emergency service provider should, but is not required to, notify his~~/her~~ designated officer within 72 hours after the exposure if ~~s/~~he wishes a report of exposure to be filed.

(5) It is the department's interpretation that the information ~~that~~ in 50-16-702(2)(c), MCA~~,~~ requires a health care facility to provide to a designated officer in response to the filing with the facility of a report of exposure is limited to information related to the health care facility stay directly resulting from the incident that generated the exposure, and not to any subsequent emergency transport to that facility involving the same patient and the same emergency medical service. This interpretation is advisory only and not binding upon anyone.

AUTH: Sec. 50-16-705, MCA
IMP: Sec. 50-16-702 and 50-16-705, MCA

4. The rules 37.104.219, 37.104.220, 37.104.317, 37.104.318, 37.104.327, 37.104.328, 37.104.402 and 37.104.403 as proposed to be repealed are on pages 37-25655, 37-25656, 37-25671, 37-25672, 37-25675 and 37-25685 of the Administrative Rules of Montana.

AUTH: Sec. 50-6-323, MCA
IMP: Sec. 50-6-323, MCA

5. The Department is proposing these amendments to the administrative rules at ARM Title 37, Chapter 104 pertaining to emergency medical services (EMS). The Department believes these amendments are necessary to conform the EMS licensing rules to current emergency medical technician (EMT) certification and medical control standards adopted by the Montana board of medical examiners (BME), more commonly abbreviated as "BOME" and to accommodate technologies that have come into common use since the rules were originally adopted. The Department is also taking this opportunity to repeal obsolete rules and to restructure the rules so they will be easier to read and use.

The BOME adopted ARM 24.156.2701 through 24.156.2775 pertaining to emergency medical technician (EMT) licensing effective January 30, 2004. These proposed rules would conform the emergency medical service license regulations to the BOME EMT license structure and current practice. The BOME rules added new levels of care called "endorsements" above the EMT-First Responder, EMT-Basic, EMT-Intermediate and EMT-Paramedic levels. Current

Department EMS licensing rules do not allow services to provide these new endorsement levels of patient care. Without authorization to use these endorsement levels of care, services would not legally be able to provide these new lifesaving skills to their communities and patients.

EMS providers that must read and understand the Department's service licensing rules must also read and understand the BOME EMT licensing rules. The Department considered and rejected the option of adopting its own terminology and process to allow endorsement levels of care. By crafting these EMS service licensing rules to compliment the BOME rules the Department intends to avoid possible confusion and to make it easier for a provider to read and meet the requirements of both. The Department believes the simplification and restructuring of these rules will eliminate obsolete and ambiguous language and will avoid differences of interpretation that might compromise public health and safety.

There is no other practical option but to propose these rule changes. Services are currently allowed to provide endorsement level of care through a waiver process provided for under current rules. Waivers are temporary measures that can only be granted for up to six months at a time. Continued use of the waiver process requires services to reapply every six months for authorization to provide endorsement level care. The Department believes this is a hardship on those services and requires unnecessary paperwork that will eventually result in considerable frustration of the services.

RULE I

The Department is proposing to remove the basic equipment kit requirements from ARM 37.104.101(6), a definitions rule, and put them in this separate new rule. The Department is taking this opportunity to update the format and structure of the rules to conform to current Montana rulemaking format and to make both rules easier to read. The Department intends no substantive change as a result of this proposal.

RULE II

The Department proposes to define two different EMS service licenses: advanced life support (ALS) and basic life support (BLS). Current service licensing rules require the Department to license services as basic life support, defibrillation life support, intermediate life support and advanced life support levels. The BOME rules eliminated the license category "EMT-defibrillation" (EMT-D). Therefore, the Department is proposing to remove references to EMT-D throughout the Chapter.

This proposed rule would integrate former EMT-I, EMT-P and the intervening endorsement levels above basic life support into a single advanced life support category. Without the proposed

change, EMS services would have to reconcile BOME EMT practice limitations with a much different EMS licensing structure. Consolidating the levels of EMS care above the basic life support level to conform it to BOME standards will make it easier to understand the level of care provided by an EMS provider and will minimize unnecessary confusion for the services and the public.

Rule II(1)(a) provides for an exception to the general rule that services above EMT-B require advanced life support licensing. The endorsement for EMT-Basic 2 - Monitoring authorizes the use of pulse oximetry and glucose monitors which are noninvasive. While there may be some justification for having medical oversight for these skills in the training for this endorsement (as is required under the BOME rules), it is not necessary to require a service medical director for the ongoing provision of this level of care. If this exception to the rule was not adopted, any EMS providing services at endorsement level EMT-Basic 2 would be required to have a medical director. Communities with little or no physician presence may experience a hardship meeting the service medical director requirement and may not be able to provide this important level of care at all.

Current rules require any EMS service that provides advanced life support, whether full-time (24 hours a day, seven days a week) or "part-time", to be licensed at an advanced life support level. Many small communities have only a few staff members that can provide advanced life support, but choose to use them whenever they are available. Rule II(2)(b) provides that an EMS service with limited ability to provide full-time ALS will be licensed at basic life support level with authorization to provide ALS. Such services would be required to develop a "service plan" explaining how they plan to provide these limited services. This rule change is necessary in order to provide the services, the medical community and the public an accurate description of the level of care available to them. EMS should not be subject to liability for exceeding their license authority if they cannot reasonably guarantee an advanced level of care to all patients they may be required to respond to.

RULE III

This proposed new rule is necessary to clearly define which agencies must apply for a nontransporting medical unit license. The current rule requires any agency that provides a medical response as part of its primary objective to be licensed. It was not the Department's intent to require agencies such as law enforcement, mine rescue units and ski patrols, whose primary purpose is public safety or rescue to obtain an EMS license. Without the proposed rule change, the Department will have to continually respond to inquiries caused by the ambiguity of this rule.

RULE IV

This new rule would remove safety and extrication kit requirements from ARM 37.104.101(34), a definitions rule, and put them in a new separate rule. The Department is taking this opportunity to update the form and structure of the rules to conform them to current Montana rulemaking practice. This proposal would make both rules easier to read by putting this subject in a separate new rule. The Department intends no substantive change as a result of this proposal.

RULE V

This new rule would remove transportation kit requirements from ARM 37.104.101(40), a definitions rule, and put them in a new separate rule. The Department is taking this opportunity to update the form and structure of the rules to conform to current Montana rulemaking practice and to make them easier to read by putting this subject in a separate new rule. The Department intends no substantive change as a result of this proposal.

RULE VI

This new rule would remove license renewal information from ARM 37.104.106, a rule about the administration of new licenses, and put it in a new separate rule. The Department is taking this opportunity to update the form and structure of the rules to conform to current Montana rulemaking practice and to make both rules easier to read by putting this subject in a separate new rule. The Department intends no substantive change as a result of this proposal.

RULE VII

This new rule would remove advertising restriction policy from ARM 37.104.106, license application requirements, and put it in a new separate rule. The Department is taking this opportunity to update the form and structure of the rules to conform them to current rulemaking practice. The proposed change would make both rules easier to read by putting this subject in a separate new rule. The Department intends no substantive change as a result of this proposal.

RULE VIII

This new rule would remove standard of care policy information from ARM 37.104.213, personnel requirements, and put it in a new separate rule. The Department is taking this opportunity to update the form and structure of the rules to conform them to current rulemaking practice. The proposed change would make both rules easier to read by putting this subject in a separate new rule. The Department intends no substantive change as a result of this proposal.

RULE IX

This new rule would remove level of care limitations from ARM 37.104.213, personnel requirements, and put them in a separate new rule. The Department is taking this opportunity to update the form and structure of the rules to conform them to current rulemaking practice. The proposed change would make both rules easier to read by putting this subject in a separate new rule. The Department intends no substantive change as a result of this proposal.

The Department is also proposing the addition of new (2) to allow EMTs to provide advanced life support on a BLS service as provided in Rule II. This will allow a BLS service some personnel scheduling flexibility when ALS certified personnel are not always available.

RULE X

This new rule would remove service operation policy from ARM 37.104.213, personnel requirements, and put it in a new separate rule. The Department is taking this opportunity to update the form and structure of the rules to make them easier to read by putting this subject in a separate new rule. The Department intends no substantive change as a result of this proposal.

RULE XI

This proposed rule is necessary to specify that a basic life support service applying for authorization to provide advanced life support under Rule II must apply on forms requesting this authorization and that they must have an approved service medical director.

ARM 37.104.101

In order to maintain the alphabetic order of the definitions, some definitions will be renumbered due to the addition and deletion of various definitions.

The Department proposes the addition of new definition (1), "Advanced life support". This proposed definition is necessary to conform the terminology used in these rules to that of the BOME rules. The Department proposes to simplify the definitions rule by referring to ALS as an advanced life support provider as defined in BOME rules. This definition would also consolidate intermediate, paramedic and endorsement levels of care under one level of care, allowing the Department to more efficiently manage licenses for services that provide multiple levels of care. Subsequent definitions would be renumbered.

ARM 37.104.101(1)

The Department proposes the amendment and renumbering of definition (1), "Advanced life support service" to (2). This proposed definition compliments the definition of ALS and allows

a service to have one advanced life support license that encompasses all levels.

ARM 37.104.101(2)

The Department proposes the amendment and renumbering of definition (2), "Advanced life support kit" to (3). Current rules specify an ALS kit with specific supplies and equipment. Additionally, current rules also allow a service medical director to customize this kit somewhat by applying to the Department for an exception to the rule if he or she determines that equipment is not necessary or required for the EMT's practice. The new BOME rules clearly put the responsibility for medical oversight of an EMT's practice within the service medical director's responsibilities. Therefore, this proposed rule would allow the service medical director to specify a customized ALS kit appropriate to the level of care that will be provided by the service.

The Department also proposes to delete (2)(a), (b), (c) and (d) describing the requirements for an EMT kit. EMT intermediate care and the associated kit are now broadly defined as advanced life support and an advanced life support kit. Therefore, this definition would be unnecessary.

ARM 37.104.101(3) and (4) would be renumbered (4) and (5) respectively.

ARM 37.104.101(5)

The Department proposes the renumbering and amendment of section (5) to (7) to maintain alphabetical order. Current rules require services to use only AEDs approved by the Department. A Department approved AED is identical to one approved by the U.S. Food and Drug Administration (FDA). This proposed rule would simplify the AED requirement to units approved by the FDA. ARM 37.104.101(5)(a) and (5)(b) would be deleted as inherent in the FDA approval process.

ARM 37.104.101(6)

The Department proposes the addition of new (6). It is necessary to define the term "authorization" used in Rule II. Failure to clearly define an authorization would open Rule II to differing interpretations and might result in challenges to the Department's licensing authority.

The Department proposes the amendment and renumbering of existing section (6), "Basic equipment kit" to (8) to maintain alphabetical order. The amendment would simplify this rule by removing substantive provisions and putting them in new separate rules. The requirements formerly in this definition would be moved to Rule I. For more information, please see the discussion of Rule I above.

ARM 37.104.101(7) would be renumbered (10) to maintain alphabetical order.

ARM 37.104.101(8) would be renumbered (12) to maintain alphabetical order.

ARM 37.104.101(9)

The Department proposes the deletion of existing section (9), "Defibrillation protocol", and the adoption of new section (9), defining "Basic life support (BLS)".

The defibrillation protocol falls under the BOME's authority and it is not necessary to duplicate it in these service licensing rules.

The proposed new definition is necessary to conform the Department's definition of BLS to the BOME rules. The Department proposes to simplify the definitions rule by removing substantive provisions and putting them in new separate rules.

ARM 37.104.101(10)

ARM 37.104.101(10) "Emergency medical technician-basic (EMT-B)" would be amended and renumbered (13) to maintain alphabetical order. The amendment would conform these rules to the BOME terminology.

The proposed definition is necessary to conform the Department's definition of EMT-B to the BOME rules. The Department proposes to simplify the definitions rule by removing substantive provisions and putting them in new separate rules. Therefore, this proposed definition of EMT-B refers to Rule II.

ARM 37.104.101(11)

The Department proposes that section (11) be amended and renumbered to (14) to maintain alphabetical order. This definition would allow simplification of several other rules by defining the term "EMT-basic" by reference to the BOME rules.

The Department proposes a new section (11) defining the term "board" to mean the Montana Board of Medical Examiners. The board is referred to frequently in these proposed rules.

ARM 37.104.101(12)

ARM 37.104.101(12) would be deleted because EMT-Defibrillation is no longer defined or recognized by the BOME, and it is not necessary to retain it in these service licensing rules.

ARM 37.104.101(13)

The Department proposes the deletion of this definition. EMT-Defibrillation is no longer defined or recognized by the BOME, and it is not necessary to retain a definition of EMT-Defibrillation equivalent in these service licensing rules.

ARM 37.104.101(15)

The Department proposes the amendment and renumbering of section (15), "Emergency medical technician-intermediate (EMT-I) equivalent" to (18) to maintain alphabetical order. This proposed new definition would conform the rules to BOME terminology.

The Department proposes a new definition, "Emergency medical technician-first responder (EMT-F)" to conform these rules to BOME terminology. This new section is numbered (15) to maintain alphabetical order.

ARM 37.104.101(16)

The Department proposes a new definition, "Emergency medical technician-paramedic (EMT-P)" to conform these rules to BOME terminology, which is numbered (19) to maintain alphabetical order.

The Department proposes a new definition, "Emergency medical technician-first responder equivalent" would be amended to refer to the BOME rule, which is numbered (16) to maintain alphabetical order.

ARM 37.104.101(17)

Existing section (14) would be renumbered to (17) to maintain alphabetical order. This proposed amendment and renumbering would conform the Department's rules referring to EMT-I with the BOME rules.

The Department proposes to simplify the definitions rule by referring to an individual licensed by BOME as an EMT-Intermediate. It would be renumbered (20).

ARM 37.104.101(18)

The Department proposes to amend and renumber existing (15) to (18) to maintain alphabetical order. The proposed amendment of emergency medical technician - intermediate (EMI-I) equivalent would eliminate obsolete language from the definition and substitute current BOME terminology. The Department proposes to simplify the definitions rule by referring to BOME licensure.

This Department is deleting existing (18), "EMT-defibrillation life support service" because that term is no longer defined or recognized by BOME.

ARM 37.104.101(19)

The Department proposes the deletion of existing section (19), "EMT-D defibrillation kit". Please see Rule I and Rule II for an explanation of the reasons for this proposal.

ARM 37.104.101(20)

The Department proposes to delete section (20) pertaining to "EMT-intermediate kit". Existing (17), "Emergency medical technician-paramedic (EMT-P) equivalent" is amended and renumbered to (20) to maintain alphabetical order. The proposed changes would eliminate obsolete language from the definition of EMT-P equivalent and substitute current BOME terminology.

ARM 37.104.101(21)

The Department proposes to delete existing section (21). The Department proposes to simplify the definitions rule by combining two conditions under the BOME rules in one definition under the service licensing rules.

Section (22) "FAA" remains the same, but is renumbered to (21) to maintain alphabetical order.

ARM 37.104.101(23)

Existing ARM 37.104.101(23) would be deleted and the definition (24) "first responder ambulance" would be amended to cross reference the BOME rule on the subject and renumbered (22) to maintain alphabetical order.

Existing section (25), "Grandfathered advanced first aid" would be amended and renumbered to (23) to maintain alphabetical order. This proposed change would amend obsolete language and replace it with current Red Cross level of training terminology, "red cross emergency response".

ARM 37.104.101(26)

Section (26) would be deleted under this proposal. The Department proposes to eliminate the definition and use of the term "grandfathered nurse" and to require all nurses providing field care to have the signed approval of a medical director for supplemental training. Currently, a nurse who is on the roster of an ambulance service during 1992 is allowed to be "grandfathered" to provide care as an EMT-D (Emergency medical technician-defibrillation) or an EMT-I (Emergency medical technician-intermediate) without any clear authorization by the service medical director. This was reflected in the existing definitions for EMT-D (also proposed to be eliminated), EMT-I, and section (26) proposed to be deleted. Eliminating this definition would only affect approximately 50 nurses who are currently grandfathered. The revised rules in this notice would

require them to be approved by the service medical director through supplemental training as enumerated in the definition for supplemental training set forth in this rule.

A new definition, "online medical direction" would be numbered (26) and would refer to the requirements set forth in the BOME rule.

ARM 37.104.101(27)

The definition "level of service" would be amended and renumbered (24) to maintain alphabetical order. By defining "level of service" as BLS or ALS, the Department intends to simplify the definitions rule and make the terminology of these rules consistent with BOME terminology.

ARM 37.104.101(28)

The Department proposes to delete the definition of "medical control". It is no longer necessary because the role and responsibilities of a service medical director are defined under the BOME rules.

ARM 37.104.101(29)

ARM 37.104.101(29), "Nontransporting medical unit (NTU)" would be amended to refer to Rule III and would be renumbered to (25) to maintain alphabetical order.

ARM 37.104.101(30)

ARM 37.104.101(30) would be deleted because the term "offline medical director" is no longer used in these rules or by BOME.

ARM 37.104.101(31)

ARM 37.104.101(31), "Permit" would be amended to reflect the current practice of printing certificates instead of stickers and would be renumbered (27) to maintain alphabetical order.

The Department proposes a new section (31), "Service medical director" referring to the requirements of the BOME rules. This would make EMS rule terminology consistent with BOME terminology.

ARM 37.104.101(32)

The Department proposes the deletion of this definition, "protocol", and the substitution of a new definition, "statewide protocol" to make EMS rule terminology consistent with the BOME rules. The new definition would be renumbered (28) to maintain alphabetical order.

This proposed amendment is necessary to define the term as it is used in Rule II.

The Department proposes a new section (32), "Service plan". This proposed amendment is necessary to define the term as it is used in Rule II.

<u>ARM 37.104.101(33)</u>

The term "provisional license" would be renumbered (29) to maintain alphabetical order.

<u>ARM 37.104.101(34)</u>

ARM 37.104.101(34), "safety and extraction equipment" would be amended to refer to Rule IV. It would also be renumbered (30) to maintain alphabetical order.

ARM 37.104.101(35) would be renumbered (33) to maintain alphabetical order.

<u>ARM 37.104.101(36)</u>

Section (36) would be amended and renumbered (34) to maintain alphabetical order. This proposed amendment of the definition of "supplemental training" would simplify these rules by adopting BOME terminology and referring to the "level of training corresponding to the license level authorized by the service medical director," consistent with the BOME rules. The BOME rules define a service medical director's responsibility for direction of the medical aspects of a service and allow the director to specify the supplemental training nurses will need in order to provide a prehospital response as a member of an EMS service roster.

<u>ARM 37.104.101(37)</u>

The Department proposes to eliminate the definition of the term "surrogate" and its use in these rules. The term is obsolete and no longer appears in the BOME rules.

ARM 37.104.101(38) would be renumbered (35) to maintain alphabetical order.

<u>ARM 37.104.101(39)</u>

The Department proposes to eliminate the definition of the term "temporary work permit" and its use in these rules. The term is obsolete and no longer appears in the BOME rules.

<u>ARM 37.104.101(40)</u>

ARM 37.104.101(40) would be renumbered (36) to maintain alphabetical order and would be amended to refer to Rule V. For more information please refer to the discussion of that rule.

ARM 37.104.101(41)

ARM 37.104.101(41) would be amended to reflect current terminology and would be renumbered (37) to maintain alphabetical order.

ARM 37.104.101(42)

The Department proposes to eliminate the adoption by reference of the U.S. Department of Transportation's Emergency Medical Technician: Basic National Standard Curriculum. The authority for curriculum approval is regulated in BOME ARM 27.156.2741(7) and this proposal would simplify the service licensing rules by eliminating the curriculum provision.

ARM 37.104.105

The Department proposes to amend this rule to reduce the number of EMS license types to basic (BLS) and advanced life support (ALS). This would be consistent with Rule I and other rules and amendments proposed in this notice.

The Department also proposes to add a new provision to this rule specifying that a service that is unable to provide ALS 24 hours a day, seven days a week will be licensed as a BLS. This would be consistent with Rule II and other amendments proposed in this notice.

ARM 37.104.106

The Department proposes to simplify this rule by eliminating obsolete language pertaining to services existing or applying for licenses to commence on January 1, 1990.

The Department proposes to simplify the method of establishing staggered licensing and to move the provisions pertaining to license renewal to a new separate rule, Rule VI. This proposed amendment is intended to make the rules easier to read and use. The Department also proposes to remove the advertising limitations from this rule and put them in a new separate rule, Rule VII. Therefore, the limitations should be easier to read and use.

ARM 37.104.201

The Department proposes to simplify this rule by eliminating obsolete language pertaining to VHF radio requirements prior to January 1, 1996. This proposed amendment is intended to make the rule easier to read and use.

ARM 37.104.203

The Department proposes to amend this rule by eliminating references to defibrillation and EMT-D, terms that would be

obsolete if the amendments proposed in this notice are adopted.

The Department proposes to amend this rule by eliminating references to the "intermediate kit", now included in the broader definition of advanced life support kit.

The Department also proposes to simplify this rule by eliminating the references to levels of service other than basic and advanced.

ARM 37.104.208

The Department proposes to amend this rule by updating the provisions related to disposal of infectious waste. The amended rule would refer to the definition of infectious waste in 75-10-1003, MCA, and the handling, treatment and disposal requirements set forth in 75-10-1005, MCA.

The Department also proposes to amend this rule by updating the provisions related to disposal of sharp items. The amended rule would use the term "sharps" that has come into common use after this rule was adopted and would refer to the handling, treatment and disposal requirements of 75-10-1005, MCA, and the U.S. Occupational Safety and Health Administration (OSHA). These proposed amendments would make this rule consistent with the other amendments proposed in this notice.

ARM 37.104.212

The Department proposes to amend this rule by eliminating references to EMT-D, a term that is no longer used in the BOME rules and would be obsolete if the amendments proposed in this notice are adopted. The responsibility for medical oversight of an EMS by the service medical director is specified in the BOME rules and it is unnecessary to repeat that duty in this rule. Therefore, the Department proposes to strike all of (5).

The Department also proposes to amend this rule to clarify when a service must file a trip report. The Department believes the term "practicable" is unnecessarily vague and that a more specific standard should be articulated when a patient care trip report must be provided to the hospital. While it is best practice for a service to provide a report to the hospital immediately after delivering their patient, some flexibility is needed to allow services who have multiple calls back-to-back to provide the report as soon as possible. Therefore, the Department proposes a specific limit of 48 hours.

ARM 37.104.213

The Department proposes to eliminate the term "temporary work permit" from this rule. The term is obsolete and no longer appears in the BOME rules.

The Department proposes to move the standard of care provision from (1)(b) of this rule to a new separate rule, Rule VIII. This should make both rules easier to read and use. The Department intends that no substantive change in the standard results from the proposed amendment.

The Department proposes to remove references to "advanced first aid" in this rule. The term is obsolete and no longer appears in the BOME rules.

The Department proposes to delete limitations on EMT practice and to add references to BOME rule ARM 24.104.2771 governing acts of EMTs licensed in other states and the use of auto-injectors during bioterrorism attacks. The proposed amendments would make this rule consistent with the BOME rules and would provide authorization for the same acts under this EMS licensure.

The Department proposes to move provisions related to EMT level of care limitations and service operation to new separate rules, Rule IX and Rule X, respectively. These amendments should make the provisions easier to read and use. The Department intends that no substantive change to these provisions results from these amendments.

The Department proposes to amend this rule by eliminating references to EMT-I and EMT-D, terms that are no longer used in the BOME rules and would be obsolete if the amendments proposed in this notice are adopted.

ARM 37.104.218

The Department proposes to amend this rule by eliminating references to EMT-I and EMT-D, terms that are no longer used in the BOME rules and would be obsolete if the amendments proposed in this notice are adopted. Under the proposed amendment, a service medical director is required only for services providing advanced life support.

The Department proposes to add references to BOME rule ARM 24.156.2701 defining service medical director qualifications, duties and responsibilities. The amendment would make these rules consistent with BOME rules and policy. This would simplify compliance with these rules because there would be a single set of service medical director qualifications, duties and responsibilities.

ARM 37.104.221

The Department proposes to allow a service to have a two-way communications system between advanced life support service personnel and a physician approved by the service medical director, or with a 24-hour physician staffed emergency department. These amendments would allow services to choose the most appropriate means of maintaining online medical direction.

The proposed amendments would make this rule consistent with the BOME rules regulating the oversight of EMT practice and the online medical direction they must receive from a service medical director.

The Department proposes an amendment that would add a specific provision exempting a service that provides only endorsement level EMT-B 2 care as provided for in BOME rule ARM 24.156.2751 from the online medical direction requirement. This amendment is necessary to clearly state that the provision of endorsement level 2 services by a BLS does not require medical director oversight. This should avoid any differing interpretations of the rule that would lead to challenges to the Department's regulatory authority.

ARM 37.104.306

The Department proposes to simplify this rule by eliminating obsolete language pertaining to the original effective date of the rule, January 1, 1993. This proposed amendment is intended to make the rule easier to read and use. Failure to propose this amendment would unnecessarily complicate this rule and would be confusing to the services and to the public.

ARM 37.104.307

The Department proposes to simplify these rules by eliminating the incorporation of Federal Aviation Administration (FAA) regulations in this rule and in ARM 37.104.336. This amendment would eliminate unnecessary duplicate regulation while assuring the safety of air ambulance stretchers.

ARM 37.104.311

The Department proposes to update this rule by giving ground ambulances the option of using electronic carbon monoxide detectors. Since these rules were originally adopted, electronic carbon monoxide detectors have come into widespread use. These proposed rules would allow a service to use either electronic carbon monoxide detectors or disposable ones.

The Department proposes to further update this rule by exempting diesel powered ambulances from the carbon monoxide detector requirements. Since these rules were adopted, the use of diesel engines has become common in ground ambulances. Diesel engines do not produce significant amounts of carbon monoxide and, therefore, the Department finds carbon monoxide detectors are unnecessary in diesel powered ambulances. This proposed exception will eliminate the administrative cost of numerous waivers under the current rule. Since waivers are limited to a six-month maximum duration, the proposed amendment would save the Department and services the cost of renewing waivers every six months.

ARM 37.104.312

The Department proposes to update this rule by giving air ambulances the option of using electronic carbon monoxide detectors. Since these rules were adopted, electronic carbon monoxide detectors have come into widespread use. These proposed rules would allow a service to use either electronic carbon monoxide detectors or disposable ones. This amendment would make the rule for air ambulances consistent with the rule for ground ambulances.

ARM 37.104.316

The Department proposes to simplify this rule by eliminating obsolete language pertaining to personnel requirements in effect prior to January 1, 1996. This proposed amendment is intended to make the rule easier to read and use.

The Department proposes to revise the language in this rule pertaining to minimum personnel requirements for BLS ground ambulances. The current rule makes it a violation for the ambulance to respond with only one person. It is not unusual for a second crew member to respond directly to the scene while another crew member responds with the ambulance. The proposed amendment would apply the minimum personnel requirement only when a patient is loaded or transported. This revision is necessary to assure that the addition of a second crew member on the scene is an appropriate practice and is not a violation of these rules. Failure to propose this amendment would continue the existing practice of imposing the staffing requirement at the time of the response, unnecessarily restricting a BLS service's personnel scheduling flexibility.

The Department is also proposing that a reference to Rule XI be added to clearly state that BLS services with an authorization to provide ALS on a less than full time basis may do so when personnel with the necessary endorsements are available. This proposed amendment is necessary to allow BLS services to provide ALS, as authorized, without being in violation of rules. For a more detailed explanation, please see the discussion of ARM 37.104.105 above.

ARM 37.104.319

The Department proposes to revise the language of this rule pertaining to minimum personnel requirements for ALS ground ambulances. The proposed amendment would make this rule similar to ARM 37.104.316 so that a second crew member could respond directly to the scene while another crew member responds with an ambulance. The proposed amendment would apply the minimum personnel requirement only when a patient is loaded or transported. This revision is necessary to assure that the addition of a second crew member on the scene is an appropriate practice and is not a violation of these rules. Failure to propose this amendment would continue the existing practice of

applying the staffing requirement at the time of the response, unnecessarily restricting an ALS service's personnel scheduling flexibility.

The Department is also proposing to update this rule by substituting the term "advanced life support" for the term "EMT-Paramedic". This is consistent with the Department's intention, explained in Rule II, to amend the term "EMT-P" to "ALS" throughout these rules.

ARM 37.104.329

The Department is also proposing to update this rule by substituting the term "advanced life support" for the term "EMT-Paramedic". This is consistent with the Department's intention, explained in Rule II, to amend the term "EMT-P" to "ALS" throughout these rules. Failure to propose this amendment would result in the retention of obsolete language that would be confusing to services and to the public.

ARM 37.104.336

The Department proposes to simplify these rules by eliminating the incorporation of FAA regulations in this rule and in ARM 37.104.307. This amendment would eliminate unnecessary duplicate regulation while assuring that air ambulances licensed under these rules are also licensed aircraft under FAA regulations. The proposed rule change would more broadly state that aircraft must be currently licensed under FAA rules.

ARM 37.104.401

The Department proposes to simplify this rule by eliminating obsolete language pertaining to the original effective date of this rule, January 1, 1990.

ARM 37.104.404

The Department proposes to substitute the term "advanced life support" for the term "EMT-Paramedic" in this rule. This is consistent with the Department's intention, explained in Rule II, to amend the term "EMT-P" to "ALS" throughout these rules.

ARM 37.104.616

Current rules require services to use only AEDs approved by the Department. A Department approved AED is identical to one approved by the U.S. Food and Drug Administration (FDA). The Department proposes to simplify the AED requirement to units approved by the FDA. Failure to revise the AED requirement would continue the unnecessary duplication of AED approval processes.

Repealed Rules

The Department is proposing the repeal of ARM 37.104.219, 37.104.220, 37.104.317, 37.104.318, 37.104.327, 37.104.328, 37.104.402, and 37.104.403 because they refer to services provided at the EMT-D and EMT-I levels. Since EMT-D and EMT-I are no longer defined or recognized in the BOME rules, it is no longer necessary to maintain EMS licensing provisions related to those levels of service.

CUMULATIVE FISCAL IMPACTS AND NUMBER OF PERSONS AFFECTED

There are a total of 144 ambulance services and 112 nontransporting units in Montana that could be affected by this rule. Since these rules neither increase the existing license fees nor create new ones, the Department does not anticipate any financial impact on the regulated entities.

6. Interested 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 Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on August 11, 2005. Data, views or arguments may also be submitted by facsimile to (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

Dawn Sliva
Rule Reviewer

John Chappuis for
Director, Public Health and Human Services

Certified to the Secretary of State July 1, 2005.

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the adoption of new rules I through III relating to the cherry research and marketing development program)	NOTICE OF ADOPTION

TO: All Concerned Persons

1. On May 26, 2005, the Department of Agriculture published MAR Notice No. 4-14-157 regarding the proposed adoption of new rules I through III relating to the cherry research and marketing development program at page 771 of the 2005 Montana Administrative Register, Issue Number 10.

2. The agency has adopted New Rule I, ARM 4.6.301; New Rule II, ARM 4.6.302; and New Rule III, ARM 4.6.303 exactly as proposed.

3. No comments or testimony were received.

DEPARTMENT OF AGRICULTURE

/s/ Nancy K. Peterson
Nancy K. Peterson, Director

/s/ Timothy J. Meloy
Timothy J. Meloy, Attorney
Rule Reviewer

Certified to the Secretary of State, July 1, 2005.

BEFORE THE DEPARTMENT OF AGRICULTURE
OF THE STATE OF MONTANA

In the matter of the amendment of ARM 4.13.1001A and repeal of ARM 4.13.1004 relating to the state grain lab fee schedule	)	NOTICE OF AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On May 26, 2005, the Department of Agriculture published MAR Notice No. 4-14-159 regarding the proposed amendment and repeal of the above-stated rules relating to the state grain lab fee schedule at page 775 of the 2005 Montana Administrative Register, Issue Number 10.

2. The agency has amended ARM 4.13.1001A exactly as proposed.

3. The agency has repealed ARM 4.13.1004 as proposed.

4. No comments or testimony were received.

DEPARTMENT OF AGRICULTURE

/s/ Nancy K. Peterson
Nancy K. Peterson, Director

/s/ Timothy J. Meloy
Timothy J. Meloy, Attorney
Rule Reviewer

Certified to the Secretary of State, July 1, 2005.

BEFORE THE DEPARTMENT OF JUSTICE
OF THE STATE OF MONTANA

In the matter of the adoption of New Rule I concerning bonus games, amendment of ARM 23.16.209, 23.16.1802, 23.16.1803, 23.16.1805, 23.16.1823, 23.16.1901, 23.16.1906, 23.16.1907, 23.16.1908, 23.16.1909, 23.16.1909A, 23.16.1910, 23.16.1911, 23.16.1931, 23.16.2001, 23.16.2305, 23.16.2401, 23.16.2406, concerning definitions, display of antique slot machines, elimination of the video gambling machine permit fee surcharge, general specifications and software specifications for video gambling machines, the addition of testing to purposes for which illegal video gambling devices may be imported or exported by a video gambling machine manufacturer, allowable winning patterns for bingo and the repeal of ARM 23.16.1809 and 23.16.1810 concerning the permit surcharge which was eliminated	NOTICE OF ADOPTION, AMENDMENT AND REPEAL

TO: All Concerned Persons

1. On May 26, 2005, the Montana Department of Justice published MAR Notice No. 23-16-164 regarding a notice of public hearing on the proposed adoption, amendment and repeal of the above-stated rules at page 784 of the 2005 Montana Administrative Register, Issue Number 10.

2. The Department has amended ARM 23.16.209, 23.16.1803, 23.16.1805, 23.16.1823, 23.16.1909A, 23.16.1910, 23.16.1911, 23.16.1931, 23.16.2001, and 23.16.2401 as proposed; and repealed 23.16.1809 and 23.16.1810 as proposed.

3. The Department has adopted New Rule I (23.16.1910A), and amended ARM 23.16.1802, 23.16.1901, 23.16.1906, 23.16.1907, 23.16.1908, 23.16.1909, 23.16.2305, and 23.16.2406 with the following changes, stricken matter interlined, new matter underlined:

<u>NEW RULE I BONUS GAMES (23.16.1910A)</u> (1) The department

may approve bonus games ~~and free games~~ that can be ~~offered~~ awarded to the player as a result of playing video poker, keno, or bingo under the following conditions:

(a) before a bonus game may be ~~offered~~ awarded to the player, the player must achieve a win by playing a video game authorized in Title 23, chapter 5, part 6, MCA; and

(b) remains as proposed.

(2) Bonus games can ~~be offered to~~ determine any one or more of the following at no risk to the player:

(a) and (b) remain as proposed.

(c) the number of free video games awarded as authorized in Title 23, chapter 5, part 6, MCA; or

(d) the award of credit that can be redeemed for cash~~; or~~

~~(e) any combination of (2)(a) through (d)~~.

(3) Poker, keno, and bingo games ~~can be offered free to the player as a result of playing a video game authorized in Title 23, chapter 6, MCA, but cannot affect the corresponding trigger game in any way~~, authorized in Title 23, chapter 5, part 6, MCA, with or without altered play whether awarded free or for consideration, are not classified as bonus games. When subsequent games are awarded as a result of playing an authorized poker, keno, or bingo game, awards in the corresponding trigger game cannot be affected by the play of those subsequent games.

23.16.1802 DEFINITIONS (1) through (6) remain as proposed.

(7) "Game marked spots" means spots selected by a keno game that do not require player interaction.

(7) through (12) remain as proposed but are renumbered (8) through (13).

~~(13)~~(14) "Predominant game" means ~~an authorized~~ a game, authorized under Title 23, chapter 5, part 6, MCA, the play of which can result in progression to a bonus game, and ~~that~~ contributes more than 50% of the overall theoretical return.

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

~~(15)~~(16) "Royalty" means a defined hand combination, card value, and/or card position in the game of video poker which determines the award of multipliers, credit that can be redeemed for cash, free games, or altered play in subsequent games ~~and/or the award of cash~~.

(16) remains as proposed but is renumbered (17).

~~(17)~~(18) "Theoretical return" means the calculation of expected payback per 23-5-607, MCA, computed by summing the award and probability products for all ~~advertised~~ paytable combinations.

~~(18)~~(19) "Trigger game" means a game authorized under ~~23-5-603(2)~~ Title 23, chapter 5, part 6, MCA, the playing of which determines progression to bonus games, free games, or altered play in subsequent games.

(19) through (23) remain as proposed but are renumbered (20) through (24).

~~(24)~~(25) "Win" means playing a video game authorized in Title 23, chapter 5, part 6, MCA, as defined by rule, achieving

a defined paytable combination and receiving an award that can be redeemed for cash.

23.16.1901 GENERAL SPECIFICATIONS OF VIDEO GAMBLING MACHINES (1) through (1)(d)(viii) remain as proposed.

(ix) the machine must have ~~seven digit~~ nonresettable mechanical meters of at least seven digits, housed in a readily accessible locked machine area. These meters must be in a configuration prescribed by the department. The mechanical meters must be manufactured in such a way as to prevent access to the internal parts without destroying the meter. Meters must be hardwired (no quick connects will be allowed in the meter wiring system). The department may require and provide a validating identification sticker to attach to the mechanical meters to verify the meters are assigned to a specific licensed machine. The meters must keep a permanent record of:

(A) through (3) remain as proposed.

23.16.1906 GENERAL SOFTWARE SPECIFICATIONS FOR VIDEO GAMBLING MACHINES (1) through (1)(h) remain as proposed.

(i) ~~poker, keno or bingo games submitted for approval shall be subject to the laws in effect at the time of submission~~ the duration of a game shall be the period of play for a game authorized under Title 23, chapter 5, part 6, MCA, starting with the utilization of the first random number from the "previously frozen field" and ending with the last utilized random number from the "previously frozen field"; and

(j) ~~approved poker, keno, or bingo games, which do not meet requirements of ARM 23.16.1910A, must remain intact, without change, regardless of resubmission as part of another multi-variation or multi-game game software modification until July 1, 2008, at which time the game software set containing the game will be rendered obsolete and unapproved~~ paytables must be static and displayed in a form that is readable and clearly defined prior to the start of the game.

(2) and (3) remain as proposed.

23.16.1907 SOFTWARE SPECIFICATIONS FOR VIDEO POKER MACHINES (1) and (1)(a) remain as proposed.

(b) conform to the standard rules of ~~video~~ poker in the following manner:

~~(i) paytables must be static and displayed in a form that is readable and clearly defined prior to the start of the game;~~

(ii) and (iii) remain as proposed but are renumbered (i) and (ii).

~~(iv) "game" means a period of play, using a single deck of cards, starting with the first card dealt and ending with the last card dealt or drawn;~~

(c) through (e) remain as proposed.

23.16.1908 SOFTWARE SPECIFICATIONS FOR VIDEO KENO MACHINES (1) through (1)(c) remain as proposed.

(d) conform to standard rules of ~~video~~ keno ~~in the following manner~~ except:

~~(i) paytables must be static and displayed in a form that is readable and clearly defined prior to the start of the game;~~

~~(ii) "game" means a period of play starting with the first random number drawn and ending with the last random number drawn;~~

~~(iii)~~(i) game marked spots can be used to trigger free games, games with altered play, or award multipliers, ~~and bonus games~~;

(ii) game marked spots in combination with a keno win can be used to trigger bonus games, award multipliers, or award additional credit that can be redeemed for cash;

~~(iv)~~ (iii) the position, characteristics, or order of a drawn ball can affect the paytable; and

(e) remains as proposed.

23.16.1909 SOFTWARE SPECIFICATIONS FOR VIDEO BINGO MACHINES (1) through (1)(c) remain as proposed.

(d) conform to standard rules of ~~video~~ bingo ~~in the following manner~~ except:

~~(i) paytables must be static and displayed in a form that is readable and clearly defined prior to the start of the game;~~

~~(ii) "game" means a period of play starting with the first random number drawn and ending with the last random number drawn;~~

~~(iii)~~(i) the position of a drawn ball can be a material component of the game; and

(ii) each game need not produce a bingo.

(e) through (g) remain as proposed.

23.16.2305 EQUIPMENT SPECIFICATIONS (1) through (2)(f)(iii) remain as proposed.

(iv) ARM 23.16.1906(1)(a), (d) and ~~(f)~~ (e).

(3) through (6) remain as proposed.

23.14.2406 PRIZE AWARDS FOR LIVE KENO AND BINGO GAMES

(1) through (2)(b)(i) remain as proposed.

(ii) bingo games be extended in any manner so as to exceed the prize limitations; ~~and~~ or

(iii) remains as proposed.

4. A public hearing was held on June 16, 2005. Comments were received from Rich Miller, Ronda Carpenter and Mark Staples.

5. The following written comments were received and appear with the Department's responses:

Comment 1: Gambling industry representatives commented that the anticipated 36-month phase-out of presently approved video game software might be unduly burdensome for some licensees who would be required to purchase updated game software, and it would be easier, and more efficient, to continue approval of the noncompliant game software.

Response 1: Upon examination of this issue, the Division determined the issue is already controlled by current rule 23.16.1901(1)(a). This rule provides that game software submissions must meet specific law and rule requirements in effect at the time of submission to the Division. Therefore, game software that has already been approved does not become obsolete even though it may not meet the requirements of the latest laws and rules. Consequently, the Division has withdrawn the proposal.

Comment 2: Gambling industry members and representatives commented that the proposed rules should allow a bonus game alone to be the award for a win in bingo, poker, or keno. The Gambling Industry Association, Inc. (GIA) advocated the position that a win is the award of credits or the chance to win credits in the future, but agreed compelling and logical arguments support the position that "achieving a win" means a paytable win that may be redeemed for cash.

Response 2: The Division believes New Rule I Bonus Games is concise and definitive as proposed and conforms to the requirements of the law. Bonus games to be offered in video gambling machines are games other than bingo, poker, or keno, and which are offered as a prize for playing and achieving a win in the games of bingo, poker, or keno. The rule explains what conditions must be met prior to offering a bonus game for play. The rule further sets out what can be obtained by the player as a result of participating in a bonus game. Because the games of bingo, poker, and keno do not include a bonus game, a win in trigger games must pay credits according to the paytable. This issue was discussed with the Gaming Advisory Counsel Subcommittee and its members were satisfied with this reasoning.

Comment 3: The GIA suggested the Division reword 23.16.209(1) to place "or an antique slot machine" before "as defined in 23-5-112, MCA," because it was thought to make its meaning clearer.

Response 3: Antique slot machines are not defined in ARM 23-5-112, MCA. An illegal gambling device is defined in 23-5-112, MCA, to include "a slot machine except as provided in 23-5-153," relating to possession and sale of slot machines that are more than 25 years old. Thus, the proposed change would not improve the clarity of the rule.

Comment 4: Gambling industry members and representatives suggested changing the language "or the award of cash" to read "or the award of credits which may be redeemed for cash," in order to make the language conform to the statute.

Response 4: The Division agreed that the change should be made to conform to the statute and for consistency within the remainder of the administrative rules for gambling.

Comment 5: Gambling industry members and representatives

pointed out that the proposed rules contained an erroneous reference to "Title 23, chapter 6."

Response 5: The error has been corrected to read, "Title 23, chapter 5, part 6" when it relates to statutes related to video gambling machines.

Comment 6: Gambling industry members and representatives suggested that the reference in ARM 23.16.1901 to a "seven digit" nonresettable mechanical meters should be changed to provide for such meters to have "at least seven digits."

Response 6: The Division agrees that the seven-digit requirement is merely a minimum number of digits required by law, and a greater number of digits in the meters could improve monitoring.

Comment 7: Gambling industry members and representatives commented that the reference in ARM 23.16.1907(1)(b) to "the standard rules of video poker..." is an error because there are no standard rules for video poker.

Response 7: The Division agrees with the comment and has removed the word "video" from that sentence.

Comment 8: The GIA commented that the reference in ARM 23.16.1909(1)(d) to "the standard rules of video bingo" is in error as there are standard rules of bingo, but not video bingo.

Response 8: The Division agrees with the comment and has removed the word "video" from that sentence.

Comment 9: The GIA commented that while they understood the intent of striking ARM 23.16.1909(1)(e) - to remove the requirement that a video bingo machine must produce a bingo in every game - language should be added to clearly establish that intent.

Response 9: The Division agrees with the comment and has added language to clearly establish the intent.

Comment 10: Gambling machine manufacturer xU1 Gaming suggested deleting the reference to "free games" in the New Rule I Bonus Games because the section deals only with bonus games.

Response 10: The Division agrees with the suggested change and has removed the words "free games" in section (1) of New Rule I.

Comment 11: Gambling machine manufacturer xU1 Gaming suggested rewording the language in subsection (1)(a) of the New Rule I Bonus Game from "bonus games can be offered to determine..." to provide that a bonus game may be "awarded" to a player. It believes the term "offered" suggests "advertised" and that is

not prohibited by the rule.

Response 11: The Division agrees with the suggested change and has substituted the word "awarded" in place of the word "offered."

Comment 12: Gambling machine manufacturer xU1 Gaming suggested striking "be offered to," and following "any one" adding "or more" in section (2) of New Rule I Bonus Games. The suggestion is for simplification and clarification.

Response 12: The Division agrees with the suggestions and has implemented the changes.

Comment 13: Gambling machine manufacturer xU1 Gaming suggested striking "free video games awarded" from subsection (2)(c) of New Rule I Bonus Games and inserting "subsequent games affected by the bonus games." The suggestion was that the revision makes the rule apply to free games as well as to games with altered play.

Response 13: The Division believes the issue of affecting subsequent games is sufficiently covered by subsections (2)(b) and (c) and the suggested changes are unnecessary.

Comment 14: Gambling machine manufacturer xU1 Gaming suggested substantially editing section (3) of New Rule I Bonus Game. It commented that the provision that free games "cannot affect the corresponding trigger game" is too vague and broad, and proposed substituting "awards in the corresponding trigger game cannot be affected by the play of subsequent games."

Response 14: The Division agreed with the comment because it provides for the inclusion of games with altered play and is consistent with the intent of the law. The proposed changes have been implemented.

Comment 15: Gambling machine manufacturer xU1 Gaming suggested adding "multipliers" to the possible awards for "Royalties" under ARM 23.16.1802(15), because the omission appears to be in error.

Response 15: The Division agrees with comment and has implemented the suggested change.

Comment 16: Gambling machine manufacturer xU1 Gaming suggested replacing "all advertised paytable combinations" with "all possible outcomes" in the definition of "theoretical return" in ARM 23.16.1802(17). The comment is that the proposed language would leave no room for misinterpretation.

Response 16: The Division agreed to delete the word "advertised" from "advertised paytable combinations," as it was unnecessary. The Division rejected the proposal to replace the

language with "all possible outcomes." It was believed that this proposed language was too broad, and would not appear to require a tie to the paytable.

Comment 17: Comments from xU1 Gaming suggested that the Division consider whether the rules made sufficiently clear that game marked spots could award credits if a defined combination of game marked spots is achieved simultaneously with a traditional keno win. Similarly, xU1 Gaming commented that the rules should be clear that game marked spots, in combination with a traditional keno win, can trigger a bonus game.

Response 17: In order to clarify this position, the Division amended ARM 23.16.1908(1)(d) to provide that game marked spots in combination with a keno win can be used to trigger bonus games, award multipliers or award additional credits that can be redeemed for cash.

Comment 18: Comments from xU1 Gaming suggested that amendments to ARM 23.16.1908(1)(d)(iv) describing the other features of video keno that can affect the paytable should include "characteristics" of the drawn ball.

Response 18: The Division agrees that this is a reasonable addition to the video keno features that can affect the paytable and has added the word "characteristics."

Comment 19: The GIA commented that the terms "predominant games" and "trigger games" in the proposed rules are not always used as defined.

Response 19: The Division maintains that the definition of "trigger game" is sufficiently concise as proposed, but agreed to modify the definition of "predominate game" in ARM 23.16.1802 for clarification.

Comment 20: The GIA commented that the terms "game marked spots" and "player marked spots" needed further definition within the rules.

Response 20: The Division maintains that the term "player marked spots" appears to be self-explanatory and is similar to the terms used in the statutory definition of keno. The Division agreed that "game marked spots" should be defined and the rule related to game marked spots be separated from the definitional section. The changes have been implemented in ARM 23.16.1802.

Comment 21: Gambling machine manufacturer IGT requested clarification on whether the requirement that video gambling machine clocks automatically account for daylight savings time would affect games already approved.

Response 21: The Division views this rule requirement as

prospective only, and would not apply to approved games currently in operation.

<u>Comment 22</u>: Gambling machine manufacturer IGT requested removing the requirement for seven digit (or greater) meters. IGT states that other jurisdictions are omitting requirements for hard meters in favor of other reliable technology.

<u>Response 22</u>: While electronic accounting and other technology has been implemented in other jurisdictions, the requirements for a combination of mechanical and electronic meters is necessary for video gambling machines operating in Montana.

<u>Comment 23</u>: Gambling machine manufacturer IGT suggested that the definition in ARM 23.16.1909 for game duration of video bingo machines should include an evaluation following the last number drawn.

<u>Response 23</u>: The Division determined that the specification of a game duration will apply to all video gambling machines; therefore, the provision has been moved to ARM 23.16.1901 as a specification for video gambling machines generally.

<u>Comment 24</u>: Gambling machine manufacturer IGT commented that the list of the various disallowed prize award for live keno and bingo games, under ARM 23.16.2406, should be exclusive, and the proper connector should be "or."

<u>Response 24</u>: The Division agrees with the comment and has implemented the suggested change.

<u>Comment 25</u>: John McMaster, staff to the Law and Justice Interim Committee, commented that instead of deleting the definition of "Draw Poker" from the definitions in ARM 23.16.1802, definitions for "Stud" and "Hold'em" be added. Without these definitions the reference to poker games, "as defined in this rule" has no meaning.

<u>Response 25</u>: The Division disagrees. The proposed definition of Video Poker, ARM 23.16.1802(24), requires that, "varieties of draw poker, stud, and hold'em must be found in the department's authority reference used for the live game of poker." The live game authority reference is ARM 23.16.1202(1). Specific authority references in the rule are, The Official Montana Poker Rulebook (1990 Edition) and Scarne's Encyclopedia of Card Games, copyright 1983, by John Scarne, pages 18 through 276.

By: <u>/s/ Mike McGrath</u>
MIKE McGRATH, Attorney General
Department of Justice

/s/ Ali Bovingdon
ALI BOVINGDON, Rule Reviewer

Certified to the Secretary of State July 1, 2005.

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

In the matter of the adoption of NEW RULE II (ARM 8.32.1722), NEW RULE V (ARM 8.32.1725), NEW RULE VI (ARM 8.32.1726), NEW RULE VII (ARM 8.32.1727), NEW RULE VIII (ARM 8.32.1728), NEW RULE XIII (ARM 8.32.1732), and the transfer and amendment of ARM 8.32.1712 (8.32.1733) pertaining to delegation	)	CORRECTED NOTICE OF ADOPTION AND TRANSFER AND AMENDMENT

TO: All Concerned Persons

1. On January 13, 2005, the Board of Nursing (Board) published MAR Notice No. 8-32-64 regarding the proposed adoption and repeal of the above-stated rules at page 30 of the 2005 Montana Administrative Register, issue no. 1. On June 30, 2005, the Board published the notice of adoption and transfer and amendment of the above-stated rules at page 1022 of the 2005 Montana Administrative Register, issue no. 12.

2. In preparing replacement pages for the second quarter of 2005, it was discovered that in the notice of adoption and transfer and amendment the reference to New Rule IX was inadvertently left in; however, New Rule IX was not adopted. The correct references were inadvertently not inserted. This corrected notice inserts the correct rule numbers. A percentage sign was inadvertently left out of New Rule XIII and is being inserted. Also, punctuation is being corrected to make the rule consistent in ARM 8.32.1712 (8.32.1733). The rules as corrected read as follows, deleted matter interlined, new matter underlined:

<u>(NEW RULE II) 8.32.1722 DEFINITIONS</u> The following words and terms as used in this sub-chapter have the following meanings:

(1) and (2) remain as adopted.

(3) "Advanced delegation" means delegation of specified advanced nursing tasks to specified UAPs only as allowed in [NEW RULE X<u>, XI, XII and XIII</u> (ARM 8.32.1729<u>, 8.32.1730, 8.32.1731 and 8.32.1732)</u>] and under immediate supervision.

(4) through (23) remain as adopted.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-131, 37-8-202, MCA

<u>(NEW RULE V) 8.32.1725 STANDARDS RELATED TO THE FACILITY'S CHIEF NURSING OFFICER REGARDING DELEGATION PRACTICES</u> (1) through (1)(c) remain as adopted.

(d) with respect to advanced delegation as provided in

[NEW RULE ~~IX~~ X, XI, XII and XIII (ARM 8.32.1729, 8.32.1730, 8.32.1731 and 8.32.1732)], the UAP's satisfactory completion of education and maintenance of certification is verified;

(e) through (2) remain as adopted.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-131, 37-8-202, MCA

(NEW RULE VI) 8.32.1726 STANDARDS RELATED TO THE NURSE FUNCTIONING AS A DELEGATOR (1) through (1)(e)(i) remain as adopted.

(ii) For advanced delegation as authorized in [NEW RULE ~~IX~~ X, XI, XII and XIII (ARM 8.32.1729, 8.32.1730, 8.32.1731 and 8.32.1732)], the delegating nurse shall provide immediate supervision for any delegated nursing task.

(iii) through (4) remain as adopted.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-131, 37-8-202, MCA

(NEW RULE VII) 8.32.1727 NURSING TASKS RELATED TO MEDICATIONS THAT MAY BE DELEGATED (1) and (2) remain as adopted.

(3) In advanced delegation, administration of medication is restricted as specified in [NEW RULE ~~IX~~ X, XI, XII and XIII (ARM 8.32.1729, 8.32.1730, 8.32.1731 and 8.32.1732)].

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-131, 37-8-202, MCA

(NEW RULE VIII) 8.32.1728 GENERAL NURSING FUNCTIONS AND TASKS THAT MAY NOT BE DELEGATED (1) remains as adopted.

(2) Nursing interventions, including but not limited to the following, require nursing knowledge, judgment, and skill and may not be delegated except as provided in [NEW RULES VII ~~and~~, X, XI, XII and XIII (ARM 8.32.1727, 8.32.1729, 8.32.1730, 8.32.1731 and 8.32.1732)]:

(a) through (4) remain as adopted.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-131, 37-8-202, MCA

(NEW RULE XIII) 8.32.1732 ADVANCED DELEGATION TO UAP NURSING STUDENTS

(1) through (2)(e)(iv) remain as adopted.

(v) 5% dextrose in .45% saline (D51/2NS); and

(vi) through (3)(l) remain as adopted.

AUTH: 37-1-131, 37-8-202, MCA
IMP: 37-1-131, 37-8-202, MCA

~~(8.32.1712)~~ 8.32.1733 TASKS WHICH MAY BE ROUTINELY ASSIGNED TO AN UNLICENSED PERSON IN ANY SETTING WHEN A NURSE-PATIENT RELATIONSHIP EXISTS (1) through (1)(b)(v) remain as

adopted.

(c) ambulation, positioning, and turning~~,~~;

(d) personal hygiene and elimination~~,~~;

(e) oral feeding, cutting up food, or placing of meal trays~~,~~;

(f) socialization activities~~,~~;

(g) activities of daily living~~,~~;

(h) through (h)(vi) remain as adopted.

AUTH: 37-8-202, MCA
IMP: 37-8-202, MCA

/s/ MARK CADWALLADER	/s/ KEITH KELLY
Mark Cadwallader,	Keith Kelly, Commissioner
Rule Reviewer	DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State July 1, 2005

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

In the matter of the amendment of ARM 24.189.601 application procedures, and ARM 24.189.620 licensees from other states or Canadian jurisdictions	)))))	NOTICE OF AMENDMENT

TO: All Concerned Persons

1. On May 12, 2005, the Board of Psychologists (Board) published MAR Notice No. 24-189-28 regarding the public hearing on the proposed amendment of the above-stated rules relating to application procedures and licensees from other states or Canadian jurisdictions, at page 729 of the 2005 Montana Administrative Register, issue no. 9.

2. A public hearing on the notice of the proposed amendment of the above-stated rules was held on June 2, 2005.

3. The Board did not receive any comments or testimony on ARM 24.189.601 or ARM 24.189.620.

4. The Board amends ARM 24.189.601 and ARM 24.189.620 exactly as proposed.

BOARD OF PSYCHOLOGISTS
JAY PALMATIER, PhD, CHAIRPERSON

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

/s/ MARK CADWALLADER
Mark Cadwallader
Rule Reviewer

Certified to the Secretary of State July 1, 2005.

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

In the matter of the amendment of ARM 37.106.704 pertaining to minimum standards for a critical access hospital	))))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On May 26, 2005, the Department of Public Health and Human Services published MAR Notice No. 37-348 pertaining to the proposed amendment of the above-stated rule pertaining to minimum standards for a critical access hospital, at page 804 of the 2005 Montana Administrative Register, issue number 10.

2. The Department has amended ARM 37.106.704 as proposed.

3. No comments or testimony were received.

4. This rule will be applied retroactively to July 1, 2005.

Dawn Sliva	Robert E. Wynia, MD
Rule Reviewer	Director, Public Health and Human Services

Certified to the Secretary of State July 1, 2005.

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

In the matter of the amendment of ARM 37.108.219 and 37.108.507 pertaining to managed care quality assurance	))))	NOTICE OF AMENDMENT

TO: All Interested Persons

1. On May 26, 2005, the Department of Public Health and Human Services published MAR Notice No. 37-349 pertaining to the proposed amendment of the above-stated rules pertaining to managed care quality assurance, at page 807 of the 2005 Montana Administrative Register, issue number 10.

2. The Department has amended ARM 37.108.219 and 37.108.507 as proposed.

3. No comments or testimony were received.

Dawn Sliva Rule Reviewer	Robert E. Wynia, MD Director, Public Health and Human Services

Certified to the Secretary of State July 1, 2005.

VOLUME NO. 51 OPINION NO. 4

APPROPRIATIONS - Effect of legislation prospectively limiting spending by future legislatures;
LEGISLATIVE BILLS - Effect of legislation requiring supermajority for future legislative action;
LEGISLATURE - Effect of legislation prospectively limiting spending by future legislatures;
STATUTORY CONSTRUCTION - Propriety of repeal by implication of statutory spending limitation by actions of future legislature;
MONTANA CODE ANNOTATED - Sections 15-38-203(2) (1989), 17-8-106 (2003);
MONTANA CONSTITUTION - Article V, sections 1, 11, (5), 13, 23; article VI, section 10(4); article VIII, sections 6(2), 8, 9, 13; article IX, section 5;
REVISED CODES OF MONTANA, 1947 - Sections 11-1825, -1834.

HELD: The enactment of Mont. Code Ann. § 17-8-106 by the 1981 legislature placed no enforceable limits on the spending power of a subsequent legislature.

July 5, 2005

Mr. Douglas A. Kaercher
Hill County Commissioner
315 Fourth Street
Havre, MT 59501

Dear Mr. Kaercher:

You have requested my opinion on questions regarding the application of Mont. Code Ann. § 17-8-106. That statute, enacted in 1981, purports to limit the power of subsequent legislatures to appropriate funds by establishing a "cap" on expenditures in the 1981 budget biennium and for any future biennial budget cycles. The statute provides as follows:

> Expenditure limitation -- exception. (1) Except as provided in subsection (2), the state expenditures for a biennium may not exceed the state expenditures for the preceding biennium plus the product of the state expenditures for the preceding biennium and the growth percentage. The growth percentage is the percentage difference between the average Montana total personal income for the 3 calendar years immediately preceding the next biennium and the average Montana total personal income for the 3 calendar years immediately preceding the current biennium.
>
> (2) The legislature may appropriate funds in excess of this limit from the reserve account if:

(a) the governor declares that an emergency exists; and

(b) two-thirds of the members of each house approve a bill stating the amount to be spent in excess of the expenditures limitation established in subsection (1), the source of the excess revenue to be spent, and an intention to exceed the limitation.

(3) Expenditures may exceed the expenditures limitation only for the year or years for which an emergency has been declared.

(4) The legislature is not required to appropriate the full amount allowed in any year under subsection (1).

Any questions regarding the application of the "cap" are subservient to the controlling issue of whether this statute constitutes an enforceable limitation on the amount that a subsequent legislature may appropriate. For the reasons that follow, it is my opinion that the 1981 statute cannot, consistent with the Montana Constitution, act as a control over the appropriation power of any subsequent legislative assemblies.

The Montana Constitution vests the legislative power in the legislature consisting of the House of Representatives and Senate, and in the people through the power of initiative and referendum. Mont. Const. art. V, § 1. It provides further that the legislature may enact laws only by bill passed by vote of a majority of all members present and voting. Mont. Const. art. V, § 11. The constitution contains other provisions requiring a supermajority vote on specific kinds of legislative action. See, e.g., art. V, § 13 (requiring 2/3 vote of the House to bring bill of impeachment and 2/3 vote to convict); art. VI, § 10(4) (requiring 2/3 vote to override veto); art. VIII, § 6(2) (allowing appropriation of revenue from GVW fees and fuel taxes for general purposes only by 3/5 vote); art. VIII, § 8 (requiring 2/3 vote to create state debt); art. IX, § 5 (requiring 3/4 vote to appropriate principal of coal severance tax trust fund). However, two fundamental principles are clear. First, the power of the legislature to set state expenditure levels is explicitly recognized in article VIII, sections 9 and 13 of the Montana Constitution. The legislature's constitutional spending power is plenary, subject only to those limitations placed upon it in the Constitution. See, e.g., Mont. Const. art. V, § 11(5) (prohibiting appropriations for private religious and charitable purposes to private individuals). Second, it is fundamental that in matters not subject to specific constitutional requirements to the contrary, a bill passed by simple majority vote of each house and signed by the governor becomes law.

Consistent with this constitutional design, the legislature lacks the power to pass a law that purports to establish

binding legislative spending policy for future legislatures. In Butte-Silver Bow Local Gov't v. State, 235 Mont. 398, 768 P.2d 327 (1989), the Montana Supreme Court applied this rule with respect to the administration of the Resource Indemnity Trust Tax. The issue was whether it was appropriate to expend funds from the Resource Indemnity Trust Fund for certain ongoing expenses of natural resource agencies. The local government argued that the expenses were inappropriate, relying in part on the provision of Mont. Code Ann. § 15-38-203(2) (1989) that "It is the intention of the legislature that future appropriations from the resource indemnity trust interest account not be made to fund general operating expenses of state agencies." The Court rejected the allegation that the expenditures violated the statute, stating: "[T]he Legislature generally cannot pass legislation which a future Legislature may not repeal." 235 Mont. at 406. The only exception to this rule that the Court has recognized is that a future legislature may not disavow a binding contractual obligation previously entered by the State, State ex rel. Diederichs v. State Highway Comm'n, 89 Mont. 205, 215, 296 P. 1033, 1036-37 (1931), an exception not relevant to the present question.

The view expressed by the Court in Butte-Silver Bow is consistent with the general rule followed in many other jurisdictions. For example, in Patterson v. Dempsey, 152 Conn. 431, 207 A.2d 739 (1965), the Connecticut Supreme Court considered the effect of a statute which purported to prohibit a future legislature from passing an appropriation bill containing non-appropriation substantive law provisions. The Court held the limitation ineffective, finding that the inclusion of the non-appropriation matters in the subsequent appropriation bill "was the equivalent of an affirmative enactment suspending, to the extent that the action violated [the prior statute], the prohibitory part of [the prior act]." 207 A.2d at 745. The court explained its decision as follows:

> The effect is really that of repeal by implication. "When expressions of the legislative will are irreconcilable, the latest prevails." To hold otherwise would be to hold that one General Assembly could effectively control the enactment of legislation by a subsequent General Assembly. This obviously is not true, except where vested rights, protected by the constitution, have accrued under the earlier act.

Id., quoting Moran v. Bens, 144 Conn. 27, 30, 127 A.2d 42, 44 (1956). See also, e.g., Straughn v. Camp, 293 So. 2d 689, 694 (Fla. 1974) (tax exemption granted by the Florida legislature for certain county property did not establish tax policy that a subsequent legislative session could not change, stating "It is well established that one legislature cannot bind its successors with respect to the exercise of the taxing

power . . . ."); <u>Board of Education v. Bremen Township Rural Independent School Dist.</u>, 260 Iowa 400, 148 N.W.2d 419, 424 (1967) (school board could not by resolution limit power of subsequent board to modify district boundaries, stating "one legislature cannot bind future legislatures upon such policy matters."); <u>Opinion to the Governor</u>, 97 R.I. 200, 196 A.2d 829, 832 (1964) (Legislature could not include provision in bill limiting ability of future legislature to fund operation of public bridge through certain level of debt where amount of state debt was within legislative power of subsequent legislatures).

It has been suggested that repeals by implication through exercise of the spending power are not favored, relying on certain language in the Montana Supreme Court's decision in <u>City of Helena v. Omholt</u>, 155 Mont. 212, 468 P.2d 764 (1970). Such reliance is, in my opinion, misplaced. <u>Omholt</u> considered substantive statutes, Rev. Codes Mont. 1947 §§ 11-1825 and 11-1834, requiring the State Auditor to pay over to cities a certain amount of money for deposit into the local police officer reserve fund. In 1967, the legislature passed an appropriation bill known as HB 577 that, in addition to authorizing certain spending, contained substantive language that changed the amount that the Auditor was required to remit to the cities. The Court's holding was that the substantive provision of HB 577 was invalid because the substantive change was not expressed in the title of the bill as required by article V, section 23 of the Montana Constitution, which limited bills to one subject clearly expressed in the title and voided any provision of a bill not so expressed.

The opinion in <u>Omholt</u> does contain dicta suggesting that appropriation bills should not be held to amend substantive law by implication, 155 Mont. at 222. However, the Court expressly declined to base the holding in the case on any analysis of the repeal by implication doctrine, 155 Mont. at 218 ("We need not discuss whether the provisions of the appropriation bill irreconcilably conflict with section 11-1825 and section 11-1834 and repeal the latter statutes by implication.") The Supreme Court's holding in a case consists only of those legal conclusions necessary to reach its judgment; any other legal discussion is non-binding obiter dicta. <u>State ex rel. McVay v. District Court</u>, 126 Mont. 382, 396, 251 P.2d 840, 847-48 (1953); <u>see also</u> <u>Spoklie v. Montana Dep't of Fish, Wildlife, & Parks</u>, 2002 MT 228, ¶ 32, 311 Mont. 427, 436, 56 P.3d 349, 355 (rejecting unnecessary dicta in prior opinion). The language from <u>Omholt</u> criticizing repeals by implication in appropriation statutes was not part of the Court's resolution of the case, and it therefore is not binding legal authority.

<u>Omholt</u> is also distinguishable on its facts. In that case, the legislature had passed substantive legislation creating a

ministerial duty on the part of the Auditor to make certain payments to the city. The repeal by implication argument thus revolved around whether the legislature could change through an appropriation measure a statute creating a duty on an executive branch officer. It did not deal with the question we have here, which is whether the legislature can enact a statute that purports to limit its own constitutional power to enact spending legislation in the future.

The general rule with respect to repeals by implication is that the intention of the legislature in passing the subsequent legislation controls. State ex rel. Jenkins v. Carisch Theatres, Inc., 172 Mont. 453, 458, 564 P.2d 1316, 1319 (1977) (the key to determining whether a later act repeals a former by implication "is the legislative intent in passing the subsequent act.") Whatever rule may be appropriate in the context of general statutes such as those in Omholt addressing the duties of executive branch officials, where, as here, the former statute purports to be an express limit on the lawmaking power of subsequent legislatures, action by the subsequent legislature ignoring the purported restriction in the prior act constitutes a clear indication of the legislature's intent not to be bound by the prior policy.

Under our constitution each legislative assembly is vested with the full legislative power of the state with respect to all matters that are constitutionally the subject of legislative power. There is no cap on state spending in the Montana constitution.

The authority of the 1981 legislature to set spending policy for the State ended when the 1983 legislature was seated. From that point forward, no general proscription by the 1981 legislature of spending above the amount provided by the formula set in Mont. Code Ann. § 17-8-106 could have any effect as an enforceable limit on the power of each subsequent legislative assembly to adopt a budget and appropriate state money. Nor could the 1981 legislature create a requirement that spending above a certain limit would be impermissible absent a declaration of an emergency and a supermajority vote of a subsequent legislature.

As with the prohibition of non-appropriation provisions in an appropriation bill considered by the Connecticut court in Patterson, the attempt to graft legislative limits on the exercise of the appropriation power by subsequent legislatures is ineffective if the subsequent legislature chooses to adopt conflicting legislation. As noted above, the constitution establishes that, except as otherwise specifically provided in the constitution, a law is enacted by majority vote of both houses of the legislature. Mont. Const. art. V, § 11. The 1981 legislature could not add to the constitution's list of enactments requiring a supermajority by the simple expedient of passing a law by majority vote.

Since it is my opinion that the so-called "budget cap" is of no force and effect as a limit on the appropriation power of a subsequent legislative assembly, it is not necessary to consider your specific question regarding the application of Mont. Code Ann. § 17-8-106 to specific spending proposals.

THEREFORE, IT IS MY OPINION:

> The enactment of Mont. Code Ann. § 17-8-106 by the 1981 legislature placed no enforceable limits on the spending power of a subsequent legislature.

Very truly yours,

/s/ Mike McGrath
MIKE McGRATH
Attorney General

mm/cdt/jym

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 PO 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) 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 Number and Department	2.	Go to cross reference table at end of each title which lists MCA section numbers and 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, 2005. This table includes those rules adopted during the period April 1, 2005 through June 30, 2005 and any proposed rule action that was pending during the past six-month period. (A notice of adoption must be published within six months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through March 31, 2005, 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 2004 and 2005 Montana Administrative Registers.

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

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