MONTANA ADMINISTRATIVE REGISTER

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MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 10

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 The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted.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 indicates that the proposed rule action is adopted and lists any changes made since the proposed stage. The interpretation section contains the attorney general's opinions and state declaratory rulings. Special notices and tables are inserted at the back of each register.

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NOTICE SECTION

BEFORE THE BOARD
OF THE STATE COMPENSATION MUTUAL INSURANCE FUND
OF THE STATE OF MONTANA

In the matter of the proposed amendments of rules 2.55.320 and 2.55.327 pertaining to method for assignment of classifications of employments and the construction industry premium credit program.	) NOTICE OF PUBLIC HEARING FOR) PROPOSED AMENDMENTS OF RULES) 2.55.320 and 2.55.327))))

TO: All Interested Persons:

1. On June 18, 1993, the State Compensation Mutual Insurance Fund will hold a public hearing at 2:00 p.m., in Room 303 of the State Compensation Mutual Insurance Fund Building, 5 South Last Chance Gulch, Helena, Montana, to consider the proposed amendments to rules 2.55.320 and 2.55.327 pertaining to the method for assignment of classifications of employments and the construction industry premium credit program.

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

2.55.320 METHOD FOR ASSIGNMENT OF CLASSIFICATIONS OF EMPLOYMENTS (1) - (2) remain the same.

(3) The state fund staff shall assign its insureds to classifications contained in the classifications section of the state compensation mutual insurance fund policy services underwriting manual issued July 1, 1993~~1991~~, and assign new or changed classifications as approved by the board. That section of the manual is~~are~~ hereby incorporated by reference. Copies of the classification section of the manual may be obtained from the Underwriting Department of the State Fund, 5 South Last Chance Gulch, Helena, Montana 59601.

AUTH: Sec. 39-71-2315 and 2316 MCA; IMP, Sec. 39-71-2311 and 39-71-2316 MCA.

Rationale: The underwriting department plans to reprint the underwriting manual and the reprinted classification section will now incorporate classifications approved by the board since July 1, 1991. This amendment to the rule is necessary to reflect the status of the classifications section of the underwriting manual as it will be reprinted with an issuance date of July 1, 1993.

2.55.327 CONSTRUCTION INDUSTRY PREMIUM CREDIT PROGRAM (1) - (4)(a) remain the same.

(b) The following credit percentages in lieu of the table in (a)~~(1)~~ will be used for the fiscal year beginning July 1, 1993.

Average Hourly Wage Credit Percentage

$ 8.72 or less	None
$ 8.73-$ 9.72	.25%
$ 9.73-$10.72	.50%
$10.73-$11.72	.75%
$11.73-$13.09	1.00%
$13.10-$14.09	6.00%
$14.10-$15.09	7.00%
$15.10-$16.09	8.00%
$16.10-$17.09	9.00%
$17.10-$18.09	10.00%
$18.10-$19.09	11.00%
$19.10-$20.09	12.00%
$20.10-$21.09	13.00%
$21.10 and above	14.00%

(5) - (6) remain the same.

AUTH: Sec. 39-71-2315 and 2316 MCA; IMP: Sec. 39-71-2211, 39-71-2311 and 39-71-2316 MCA.

Rationale: This amendment does not change the substance of the rule, but by correcting the incorrect notation in 4(b), it will prevent any confusion in applying the rule.

3. On March 11, 1993, the State Compensation Mutual Insurance Fund Board published a notice of adoption of amendments pertaining to the establishment of premium rates at p. 340, 1993 Montana Administrative Register, Issue No. 5. In ARM 2.55.327(3), class code 9552 in the table was incorrectly noted as 9522. It should read 9552. The 6/30/93 replacement pages will reflect the correct class code.

4. Interested persons may submit their data, views, or arguments, either orally or in writing, at the hearing. Written testimony may be submitted to state fund attorney Nancy Butler, Legal Department, State Compensation Mutual Insurance Fund, 5 South Last Chance Gulch, Helena, Montana 59604-4759, no later than 5:00 p.m. on June 24, 1993.

5. The State Fund Legal and Underwriting Departments have been designated to preside over and conduct the hearing.

Dal Smilie, Chief Legal Counsel
Rule Reviewer

James T. Harrison, Jr.
Chairman of the Board

Nancy Butler, General Counsel
Rule Reviewer

Certified to the Secretary of State 5/17, 1993.

BEFORE THE DEPARTMENT OF AGRICULTURE
STATE OF MONTANA

In the matter of the proposed adoption of New Rules on civil penalties relating to the distribution of seed in Montana; amending ARM 4.12.3007 on seed license fees; amending references to seed processing plants in Title 4, Chapter 12, Sub-chapter 30; deleting sub-sections (3) and (4) of ARM 4.12.3002 on Seed Buyers and Seed Public Warehouses; and repealing of ARM 4.12.3006 on bonding of Seed Buyers and Seed Public Warehouses	NOTICE OF PROPOSED ADOPTION OF NEW RULES ON CIVIL PENALTIES RELATING TO THE DISTRIBUTION OF SEED IN MONTANA; AMENDING ARM 4.12.3007 ON SEED LICENSE FEES; AMENDING REFERENCES TO SEED PROCESSING PLANTS IN TITLE 4, CHAPTER 12, SUB-CHAPTER 30; DELETING SUBSECTIONS (3) AND (4) OF ARM 4.12.3002 ON SEED BUYERS AND SEED PUBLIC WAREHOUSES; AND REPEALING OF ARM 4.12.3006 ON BONDING OF SEED BUYERS AND SEED PUBLIC WAREHOUSES

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On June 26, 1993, the Department of Agriculture proposes to adopt new rules on civil penalties relating to the distribution of seed in Montana; amend ARM 4.12.3007 increasing seed license fees; amend all references in Title 4, Chapter 12, sub-chapter 30 to Seed Processing Plant(s) by deleting the word "processing" and inserting the word "conditioning"; delete subsections (3) and (4) of ARM 4.12.3002 on Seed Buyers and Seed Public Warehouses; and repeal ARM 4.12.3006 on bonding of Seed Buyers and Seed Public Warehouses.

2. The proposed new rules will read as follows:

RULE I CIVIL PENALTIES - ENFORCEMENT (1) Whenever the department has reason to believe that a violation of Title 80, Chapter 5, MCA, or any adopted rule thereunder has occurred and the department finds it in the public interest to assess a civil penalty, it may initiate a civil penalty action pursuant to the Administrative Procedure Act.

(2) Each violation shall be considered a separate offense and is subject to a separate penalty not to exceed $1,000. Each violation within a lot of seed may be considered

a separate offense. A repeat violation shall be considered a first violation if it occurred two or more years after the previous violation.

(3) The penalty matrixes set forth in this rule establish the basic penalty value for each offense. Factors dealing with the violation may cause the matrix penalty to increase or decrease. Examples of such factors would be the firm's history of compliance or non-compliance, or the extent of the harm to agriculture or environment.

AUTH: Chapter 602, 1993 Laws of Montana IMP: Chapter 602, 1993 Laws of Montana

RULE II CIVIL PENALTIES - MATRIX

Type of Violation	1st Offense	2nd Offense	Subsequent Offenses
(1) Operating without a seed license or refusal to pay the licensing fee required after being fully advised of its requirement.	$100	$300	$1000
(2) Misrepresenting information supplied supplied regarding exemption from licensing requirements.	$100	$300	$1000
(3) Distributing or offering for sale seed lots that:			
(a) contain technical violations in labeling that do not seriously affect the quality of the seed	$100	$300	$500
(b) are lower in germination than the tolerance allows	$100	$300	$1000
(c) contain restricted noxious weed seed above the tolerances	$200	$500	$1000
(d) contain prohibited noxious weed seed	$200	$500	$1000
(e) seriously affect the quality of the lot of seed	$200	$500	$1000

AUTH: Chapter 602, 1993 Laws of Montana IMP: Chapter 602, 1993 Laws of Montana

3. 4.12.3007 AGRICULTURAL SEED LICENSING FEES is amended as follows: "(1) All seed ~~processing~~ conditioning plants, and seed labelers~~, seed buyers, and public agricultural seed warehouses~~ shall obtain a license at a cost of ~~$35~~ $50 per ~~year~~ license type from the department before doing business in this state.

(2) No person may distribute seed without obtaining a dealer's license at the cost of ~~$15~~ $50 per year for each place of business."

AUTH: 80-5-206, MCA IMP: 80-5-202, MCA

4. All references to "processing" or "processed" in the following rules where they appear in the subsections listed, are changed to "conditioning" or "conditioned".

4.12.3001 EQUIPMENT STANDARDS subsections (1),(1),(1)(a),(1)(f);(2);(3),(3)(b),(3)(d);(4);(5),(5)(b);(6);(7)(a),(7)(i),(7)(iii);(9).

AUTH: 80-5-206, MCA IMP: 80-5-202, MCA

4.12.3002 HANDLING PROCEDURES subsections (1),(1)(a),(1)(b), (1)(A),(1)(C).

Subsections (1) through (2)(c) remain the same. Delete subsection (3) and (4) as follows:

~~(3) Seed Buyers shall:~~

~~(a) Use a contract form which clearly states that terms of purchase and basis for payment;~~

~~(b) Submit a sample copy of the contract and subsequent revisions to the department;~~

~~(c) Determine the percentage of pure seed before transporting seed out of state;~~

~~(d) Weigh all seed at a scale designated in the contract or agreed in writing by both parties;~~

~~(e) Be responsible for the actions of his employees while performing assigned duties.~~

~~(4) Public Agricultural Seed Warehouses shall, through the warehousemen:~~

~~(a) Issue a scale ticket for each load of agricultural seed received by the warehouse. Scale tickets are not to be issued or held in lieu of warehouse receipts. There shall be plainly printed across the face of such scale tickets issued by the warehousemen in bold type, the words, "THIS IS NOT A WAREHOUSE RECEIPT BUT SHALL BE EXCHANGED FOR A WAREHOUSE RECEIPT IF AGRICULTURAL SEED IS HELD IN STORAGE".~~

~~(b) Each day, issue a warehouse receipt for each lot of agricultural seed of one kind received from one owner during any one day may be construed to be a single lot. If seed is received solely for cleaning and not to be held longer than twenty-four (24) hours the warehousemen are not required to issue a warehouse receipt. If seed is received for storage or~~

~~cleaning and storage, a warehouse receipt shall be issued.~~

~~(c) Indicate the number of the scale tickets on the warehouse receipt for which it is issued. Warehouse receipts not picked up by the owner shall be held in safekeeping for him by the warehousemen;~~

~~(d) Maintain the identity and integrity of each lot of agricultural seed when requested or when necessary to determine ownership, as it is delivered to the warehouse;~~

~~(e) Use a public seed warehouse receipt form that meets the department's specifications. Receipts shall include within their printed terms:~~

~~(i) a statement that the warehouse is operated as a public agricultural seed warehouse under license issued by the Montana Department of Agriculture;~~

~~(ii) a statement showing whether it is an original, duplicate, triplicate, or other copy. All copies other than the original shall state "Non-Negotiable";~~

~~(iii) a statement showing the name of the city or town where the public agricultural seedwarehouse is located;~~

~~(iv) a statement showing the name of the public agricultural seed warehouse;~~

~~(v) the date the public agricultural seed warehouse receipt is issued;~~

~~(vi) number the public warehouse receipt. All receipts shall be numbered consecutively as issued by each warehousemen;~~

~~(vii) a statement that the agricultural seed is "received in store" from the person or persons, or firm or corporation names;~~

~~(viii) a statement of the gross weight, tare, and net weight of the cleaned lot load in pounds, the kind of seed, and any trade designation of grade or quality;~~

~~(ix) a statement of the encumbrances such as cash or other advances;~~

~~(x) a statement that upon the return of a receipt properly endorsed by the person to whose order it was issued and the payment of the proper charges for storing and handling delivery will be made in accordance with the provision of the receipt.~~

~~(xi) a statement that the agricultural seed is properly insured for the benefit of the owner; followed by:~~

~~(xii) the name of the public warehouse issuing the warehouse receipt and the signature of the warehouse or his authorized representative;~~

~~(xiii) the face of the public warehouse receipt shall provide for other statements and records such as the scale ticket numbers or assembly sheet numbers and other pertinent accounting or bookkeeping data providing that such statements or records do not in any way conflict with any state or federal law pertaining to public agricultural seed warehousing;~~

~~(xiv) the back of the public warehouse receipt shall~~

~~embody within its written or printed terms, a statement of:~~

~~(A) that delivery to the holder of receipts shall be as provided by the laws of Montana;~~

~~(B) that receipts shall be issued only on actual delivery of agricultural seed into the warehouse and shall not be given to cover agricultural seed of which the warehouseman is owner;~~

~~(C) that delivery of agricultural seed to warehousemen for storage constitutes bailment and not a sale;~~

~~(D) that if receipts are made in multiple form, the original shall be given to the owner of the agricultural seed; all copies other than the original must be marked NON-NEGOTIABLE.~~

~~(xv) the back of the public warehouse receipt may also provide for endorsements and other statement or records pertinent to accounting or bookkeeping data providing that such statements or records do not in any way conflict with any state or federal law pertaining to public agricultural seed warehouse;~~

~~(xvi) each applicant for license shall submit a warehouse receipt and subsequent revisions to the department for review and filing.~~

~~(f) Legal public agricultural seed warehouse receipt;~~

~~(i) a legal public warehouse receipt is a receipt issued by a licensed public warehouseman on a form containing all the provisions of part (e) of this rule and shall not be issued except for agricultural seed actually delivered into a public warehouse for storage;~~

~~(ii) if, for convenience, the holder of two or more warehouse receipts covering like seed wishes to combine them into a lesser number, the new warehouse receipt or receipts so issued shall state the fact that it was issued in lieu of existing warehouse receipts, and the numbers of the warehouse receipts so combined shall state across the face, 'CANCELLED BY RECEIPT NO. _____" (showing the number of the new warehouse receipt issued in lieu).~~

~~(g) Limitation of rulings;~~

~~(i) all storage contracts on seed in storage in public agricultural seed warehouses as evidence by a warehouse receipt shall terminate on June 30 each year;~~

~~(ii) storage of any or all seed may be terminated by the owner at any time before the date mentioned herein by the payment of tender of all legal charges and the surrender of the storage receipt, together with a demand for delivery of such seed, or notice to warehousemen to sell the same. In the absence of a demand for delivery, order to sell, or mutual agreement for the renewal of the storage contracts entered into prior to the expiration of the storage contract, as prescribed in this act, the warehousemen may, upon the expiration of the storage contract, sell so much of such stored seed at the local market price on the close of business on said day as is sufficient to pay the accrued storage~~

~~charges, and shall thereupon issue new storage tickets for the balance of the seed to the owner thereof upon surrender by him of the original storage receipts. Provided further, that it shall be the duty of the warehouseman on the first day of June of each year to notify all storage ticket holders at their last known address of the provision of this section.~~

AUTH: 80-5-206, MCA IMP: 80-5-206, MCA

4.12.3003 TYPES OF SEED THAT ~~PROCESSING~~ CONDITIONING PLANTS ARE AUTHORIZED AND LICENSED TO CLEAN subsections (1),(2),(3).

AUTH: 80-5-206, MCA IMP: 80-5-202, MCA

4.12.3004 HANDLING OF SCREENINGS subsections (1),(1)(b)(ii), (2)(a).

AUTH: 80-5-206, MCA IMP: 80-5-204(2), MCA

4.12.3006 BONDING AND INSURANCE REQUIREMENTS is hereby repealed. This rule is found on pages 4-505 and 4-506 of the ARM.

AUTH: 80-5-206, MCA IMP: 80-5-206, MCA

Reasons: The reason for the new rules is to adopt a civil penalty matrix required upon passage of Senate Bill 98 during the 53rd session of the Montana Legislature. The civil penalty matrix establishes specific fines for specific violations of Montana's Seed Law and rules.

ARM 4.12.3007 is amended to increase the seed license fees to $50 per license type. Senate Bill 98 established a special revenue account to fund the expenses of the department's seed program. The increase in fees is necessary to generate revenue for the administration, licensing and enforcement of the seed program.

All reference in Title 4, Chapter 12, Sub-chapter 30 to "Seed Processing Plants" are changed to "Seed Conditioning Plants". These amendments are necessary to change the terminology in the seed rules to correspond to the terminology in statute. The statutory change in terminology from "Seed Processing" to "Seed Conditioning" occurred in 1987.

ARM 4.12.3002 is amended to delete subsections (3) and (4) of the rule pertaining to Seed Buyers and Seed Public Warehouses. All references to the functions of seed buying and seed public warehousing was deleted from the seed law (Title 80, Chapter 5) in 1983. These functions were incorporated into the Agricultural Warehouse, Commodity Dealer, and Grain Standards

Agricultural Warehouse, Commodity Dealer, and Grain Standards Act in the same year of 1983. The seed law no longer provides for the licensing and regulation of Seed Buyers or Seed Public Warehouses.

ARM 4.12.3006 relating to the bonding and insuring of Seed Buyers and Seed Public Warehouses is repealed in its entirety for the same reason subsections (3) and (4) of ARM 4.12.3002 are being deleted (refer to above).

5. Interested persons may present their data, views, or arguments either orally or in writing to Willard A. Kissinger, Administrator, Plant Industry Division, Montana Department of Agriculture, P.O. Box 200201, Helena, MT. 59620-0201, no later than June 24, 1993.

6. If a person who is directly affected by the proposed adoption wishes to express his data, views and arguments orally or in writing at a public hearing , he must make written request for a hearing and submit this request along with any written comments he has to Willard A. Kissinger, Administrator, Plant Industry Division, Montana Department of Agriculture, P.O. Box 200201, Helena, MT. 59620-0201, no later than June 24, 1993.

7. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption; from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from any association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register and mailed to all interested persons.

W. Ralph Peck
Deputy Director

Timothy J. Meloy, Attorney
Rule Reviewer
Department of Agriculture

Certified to the Secretary of State Office May 17, 1993.

BEFORE THE STATE AUDITOR AND COMMISSIONER OF INSURANCE
STATE OF MONTANA

In the matter of the general revision of rules pertaining to medicare supplement insurance	)	NOTICE OF PUBLIC HEARING REGARDING THE PROPOSED AMENDMENT AND REPEAL OF EXISTING RULES AND ADOPTION OF NEW RULES PERTAINING TO MEDICARE SUPPLEMENT INSURANCE

TO: All interested persons

1. On Friday, June 18, 1993, at 10:00 o'clock, a.m., MDT, a public hearing will be held in the east conference room on the ground floor of the Mitchell Building, 125 Roberts Street, Helena, Montana. The hearing will be to consider the proposed general revision of rules pertaining to medicare supplement insurance, including proposed repeal of some existing rules, proposed amendment of some existing rules, and proposed adoption of new rules, including charts and forms.

2. The rules proposed for repeal are ARM 6.6.502 PURPOSE; 6.6.512 SEVERABILITY; 6.6.513 EFFECTIVE DATE; 6.6.514 BENEFIT CONVERSION REQUIREMENTS DURING TRANSITION; 6.6.516 FILING REQUIREMENTS FOR OUT-OF-STATE GROUP POLICIES; and 6.6.518 FILING REQUIREMENTS FOR ADVERTISING, respectively, and are located on pages 6-119; 6-141; 6-141; 6-142; 6-142; and 6-143 of the Administrative Rules of Montana. These rules are being repealed because they unnecessarily repeat statutory language and are redundant or archaic. For each rule proposed for repeal, the authorizing and implemented statutes are as follows:

ARM 6.6.502
AUTH: Sec. 33-1-313, MCA
IMP: Sec. 33-22-902, MCA

ARM 6.6.512
AUTH: Sec. 33-1-313, MCA
IMP: Sec. 33-22-901 to 33-22-909, MCA

ARM 6.6.513
AUTH: Sec. 33-1-313 and 33-22-904, MCA
IMP: Sec. 33-15-303 and 33-22-901 through 33-22-924, MCA

ARM 6.6.514
AUTH: Sec. 33-1-313 and 33-22-904, MCA
IMP: Sec. 33-15-303 and 33-22-901 through 33-22-924, MCA

ARM 6.6.516
AUTH: Sec. 33-1-313 and 33-22-904, MCA
IMP: Sec. 33-15-303 and 33-22-901 through 33-22-904, MCA

ARM 6.6.518
AUTH: Sec. 33-1-313 and 33-22-904, MCA
IMP: Sec. 33-15-303 and 33-22-901 through 33-22-904, MCA

3. Some existing rule histories are being revised for more specific citations of statutes which the rules purport to implement. References to sections 33-22-901 through 924, MCA, should be stricken from the rule histories and specific citations should be substituted. These would include sections 33-22-904, 905, 906 and 907, MCA, or a combination thereof, depending on the subject of the rule.

4. Dollar amounts shown in ARM 6.6.507 and in the forms annexed to ARM 6.6.511 are subject to annual review and revision under 42 USC 1395 ss(p)(1)(A).

5. The rules proposed for amendment and the proposed new rules provide as follows:

6.6.503 APPLICABILITY AND SCOPE (1) Except as otherwise specifically provided, this subchapter ~~applies~~ shall apply to:

(a) All medicare supplement policies ~~and subscriber contracts~~ delivered or issued for delivery in this state on or after the effective date hereof, and

(b) All certificates issued under group medicare supplement policies ~~or subscriber contracts,~~ which ~~policies or contracts~~ certificates have been delivered or issued for delivery in this state ~~on or after the effective date hereof~~.

(2) This subchapter does not apply to~~:~~ a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

~~(a) policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual includes provisions which are inconsistent with the requirements of this regulation or;~~

~~(b) Medicare supplement policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation.~~

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

6.6.505 POLICY DEFINITIONS AND TERMS The following definitions are in addition to those in 33-22-903, MCA. No insurance policy or ~~subscriber contract~~certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if it contains, as to matters set forth in (1) through (~~11~~7) below, definitions or terms which do not conform to the requirements of this rule.

(1) "Accident", "accidental injury", or "accidental means" must be defined to employ "result" language and may not include words which establish an accidental means test or use words such

as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition may not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

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

(2) "Benefit period" or "medicare benefit period" may not be defined more restrictively than as defined in the medicare program.

(3) "Convalescent nursing home", "~~E~~extended care facility", or "~~S~~skilled nursing facility" must not be ~~defined in relation to its status, facilities, and available services~~described more restrictively than as defined in the medicare program.

~~(a) A definition of the home or facility may not be more restrictive than one requiring that it:~~

~~(i) be operated pursuant to law;~~

~~(ii) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;~~

~~(iii) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;~~

~~(iv) provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and~~

~~(v) maintain a daily medical record of each patient.~~

~~(b) The definition of such home or facility may exclude:~~

~~(i) a home, facility, or part thereof used primarily for rest;~~

~~(ii) a home or facility for the aged or for the care of drug addicts or alcoholics; or~~

~~(iii) a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial, or educational care.~~

~~(4) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses of insurers. Such expenses shall not include:~~

~~(a) home office and overhead costs;~~

~~(b) advertising costs;~~

~~(c) commissions and other acquisition costs;~~

~~(d) taxes~~

~~(e) capital costs;~~

~~(f) administrative costs; or~~

~~(g) claims processing costs.~~

(~~5~~4) "Hospital" ~~may~~must be defined in relation to its status, facilities~~,~~ and available services or to reflect its

accreditation by the joint commission on accreditation of hospitals~~.~~, but

~~(a) the definition of the term "hospital" must~~ not ~~be~~ more restrictively than ~~one requiring the hospital:~~ as defined in the medicare program.

~~(i) be an institution operated pursuant to law; and~~

~~(ii) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic, and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and~~

~~(iii) provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).~~

~~(b) The definition of the term "hospital" may exclude:~~

~~(i) convalescent homes, convalescent, rest, or nursing facilities; or~~

~~(ii) facilities primarily affording custodial, educational, or rehabilitory care; or~~

~~(iii) facilities for the aged, drug addicts, or alcoholics; or~~

~~(iv) any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis when legal liability exists for charges made to the individual for such services.~~

~~(6) "Medicare" must be defined in the policy. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act", "as then constituted and any later amendments or substitutes thereof", or words of similar import.~~

(7~~5~~) "Medicare eligible expenses" means ~~health care~~ expenses of the kinds covered by medicare, to the extent recognized as reasonable by medicare. ~~Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims;~~

~~(8) "Mental or Nervous disorders" must be defined to include at least neurosis, psychoneurosis, psychopathy, psychosis, or personality disorders of any kind.~~

~~(9) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse", "trained nurse", or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the~~

~~applicable statutes or administrative rules of the licensing or registry board of the state.~~

(~~10~~6) "Physician" ~~may~~ must not be defined ~~by including words such as~~ more restrictively than as defined in the medicare program ~~"duly qualified physician" or "duly licensed physician". The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws~~.

(~~11~~7) "Sickness" must not be defined more restrictively than the following: "Sickness means ~~sickness~~ 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, MCA IMP: 33-22-904, MCA

6.6.506 PROHIBITED POLICY PROVISIONS ~~(1) (a) No insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if such policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment, or medical condition, except as follows:~~

~~(i) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;~~

~~(ii) mental or emotional disorders, alcoholism, and drug addiction;~~

~~(iii) illness, treatment, or medical condition arising out of:~~

~~(A) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto;~~

~~(B) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;~~

~~(C) aviation;~~

~~(iv) cosmetic surgery, except that "cosmetic surgery" may not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;~~

~~(v) care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, if such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column;~~

~~(vi) treatment provided in a governmental hospital except as required in sections 33-22-112 and 33-30-1002, MCA; benefits provided under Medicare or other governmental programs (except Medicaid), any state or federal workers' compensation,~~

~~employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories, or other institutions; services performed by a number of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;~~

~~(vii) dental care or treatment;~~

~~(viii) eye glasses, hearing aids, and examination for the prescription or fitting thereof;~~

~~(ix) rest cures, custodial care, transportation, and routine physical examinations;~~

~~(x) territorial limitations.~~

~~(b) Supplement policies may not contain, when issued, limitations or exclusions of the type enumerated in subsections (i), (v), (ix), or (x) above that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.~~

(1) Except for permitted preexisting condition clauses as described in ARM 6.6.510 and 6.6.522, no policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

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

~~(3) The terms "medicare supplement," "medigap" and words of similar import must not be used unless the policy is issued in compliance with this regulation.~~

(~~4~~3) No medicare supplement ~~insurance~~ policy~~, contract~~ or certificate in force in the state of Montana shall contain benefits which duplicate benefits provided by medicare.

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

6.6.507 MINIMUM BENEFIT STANDARDS ~~(1) An insurance policy or subscriber contract certificate may not be advertised, solicited, or issued for delivery in this state as a medicare supplement policy unless it meets the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.~~

~~(2) The following general standards apply to medicare supplement policies and are in addition to all other requirements of this regulation:~~

~~(a) A medicare supplement policy may not deny a claim for losses incurred more than 6 months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage;~~

~~(b) A medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;~~

~~(c) A medicare supplement policy 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;~~

~~(d) A medicare supplement policy may not be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health, nor may such a policy provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.~~

~~(e) Except as authorized by the commissioner, an insurer shall neither cancel or nonrenew a medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.~~

~~(f) If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph (2)(h), the insurer shall offer certificateholders an individual medicare supplement policy. The insurer shall offer the certificateholder at least the following choices:~~

~~(i) an individual medicare supplement policy which provides for continuation of the benefits contained in the group policy; and~~

~~(ii) an individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards.~~

~~(g) If membership in a group is terminated, the insurer shall:~~

~~(i) offer the certificateholder such conversion opportunities as are described in paragraph (2)(f); or~~

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

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

~~(i) Termination of a medicare supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefit.~~

~~(3) A medicare supplement policy must provide the following minimum benefits:~~

~~(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through 90th day in any Medicare benefit period;~~

~~(b) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days;~~

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

~~(d) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;~~

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

~~(f) Coverage of 20% of the amount of medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ($75);~~

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

~~(4) For purposes of the standards described in this rule, medicare eligible expenses shall mean health care expenses of the kinds covered by medicare, to the extent recognized as reasonable by medicare. Payment of benefits by insurers for medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to medicare claims.~~

(1) The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards.

(a) The following standards are in addition to all other requirements of this rule.

(i) A medicare supplement policy or certificate must not indemnify against losses resulting from accidents.

(ii) 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.

(iii) 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.

(iv) Each medicare supplement policy shall be guaranteed renewable and:

(A) the issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

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

(v) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (1)(c)(vii) hereof, the issuer must offer certificateholders an individual medicare supplement policy which (at the option of the certificateholder):

(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.

(vi) If an individual is a certificateholder in a group medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(A) offer the certificateholder the conversion opportunity described in section (1)(a)(vii),

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

(vii) 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.

(A) 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.

(viii) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer must return to the policyholder or certificateholder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims.

(A) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate must be automatically

reinstituted effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(B) Reinstitution of such coverages:

(I) Must not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Must provide for coverage which is substantially equivalent to coverage in effect before the date of suspension; and

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

(b) Standards for basic ("core") benefits common to all benefit plans include the following: Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof.

(i) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(ii) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;

(iii) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(iv) Coverage under medicare Parts A and B for 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.

(c) The following additional benefits must be included in medicare supplement benefit plans "B" through "J" only as provided by New Rule I:

(i) Coverage for all of the medicare Part A inpatient hospital deductible amount per benefit period.

(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 posthospital skilled nursing facility care eligible under medicare Part A.

(iii) Coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(iv) Coverage for 80% of the difference between the actual medicare Part B charges as billed, not to exceed any

charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(v) Coverage for all of the difference between the actual medicare Part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(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.

(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.

(viii) Coverage to the extent not covered by medicare for 80% of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(ix) Coverage for the following preventive health services:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from (B) and patient education to address preventive health care measures.

(B) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(I) fecal occult blood test and/or digital rectal examination;

(II) mammogram;

(III) dipstick urinalysis for hematuria, bacteriuria and proteinauria;

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

(V) serum cholesterol screening (every five years);

(VI) thyroid function test;

(VII) diabetes screening;

(VIII) influenza vaccine administered at any appropriate time during the year and tetanus and diptheria booster (every ten years);

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

(C) Reimbursement shall be for the actual charges up to 100% of the medicare-approved amount for each service, as if medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120.00 annually under this benefit.

This benefit must not include payment for any procedure covered by medicare.

(x) Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(A) For purposes of this benefit, the following definitions apply:

(I) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(II) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(III) "Home" means any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(IV) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(B) For the purposes of this benefit, the following coverage requirements apply:

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

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

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of [$40.00] per visit.

(III) [$1,600.00] per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving medicare approved home care

services or no more than eight weeks after the service date of the last medicare approved home health care visit.

(D) Coverage is excluded for:

(I) Home care visits paid for by medicare or other government programs; and

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

(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.

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

NEW RULE I STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

(1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as established in ARM 6.6.507.

(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.

(3) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" 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 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) An issuer may use, in addition to the benefit plan designations required in (5), other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized medicare supplement benefit plan "A" must be limited to the basic ("core") benefits common to all benefit plans, as established in ARM 6.6.507(1)(b).

(b) Standardized medicare supplement benefit plan "B" must include only the following: The core benefit as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible as established in ARM 6.6.507(1)(c)(i).

(c) Standardized medicare supplement benefit plan "C" must include only the following: The core benefit as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible and medically necessary emergency care in a foreign country as established in ARM 6.6.507(1)(c)(i), (ii), (iii), and (viii).

(d) Standardized medicare supplement benefit plan "D" must include only the following: The core benefit, as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as established in ARM 6.6.507(1)(c)(ii), (viii), and (x).

(e) Standardized medicare supplement benefit plan "E" must include only the following: The core benefit as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in ARM 6.6.507(3)(1)(c)(i), (ii), (viii), and (ix).

(f) Standardized medicare supplement benefit plan "F" must include only the following: The core benefit as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the medicare Part B excess charges and medically necessary emergency care in a foreign country as established in ARM 6.6.507(1)(c)(i), (ii), (iii), (v), and (viii).

(g) Standardized medicare supplement benefit plan "G" must include only the core benefit as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible, the skilled nursing facility care, 80% of the medicare Part B excess charges, medically necessary emergency care in a foreign country and the at-home recovery benefit as established in ARM 6.6.507(1)(c)(i), (ii), (iv), (viii), and (x).

(h) Standardized medicare supplement benefit plan "H" must include only the following: The core benefit as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible, the skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as established in ARM 6.6.507(1)(c)(i), (ii), (vi), and (viii).

(i) Standardized medicare supplement benefit plan "I" must include only the following: The core benefit as established in ARM 6.6.507(1)(b) plus the medicare Part A deductible, the skilled nursing facility care, 100% of the medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as established in ARM 6.6.507(1)(c)(i), (ii), (v), (vi), (viii), and (x).

(j) Standardized medicare supplement benefit plan "J" must include only the following: The core benefit as established in ARM 6.6.507(1)(b), plus the medicare Part A deductible, the skilled nursing facility care, medicare Part B deductible, 100% of the medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as established in ARM 6.6.507(1)(c)(i), (ii), (iii), (v), (vi), (viii), and (x).

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

NEW RULE II OPEN ENROLLMENT (1) No issuer shall deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six month period beginning with the first month in which an individual (who is 65 years of age or older) first enrolled for benefits under medicare Part B. Each medicare supplement policy and certificate currently available from an insurer must be made available to all applicants who qualify under this subsection without regard to age.

(2) This rule must not be construed as preventing the exclusion of benefits under a policy, 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, MCA IMP: 33-22-904, MCA

6.6.508 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM (1) A medicare supplement ~~policies shall return to policyholders in the form of aggregate benefits under the policy,~~ policy form or certificate form must not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage~~, 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~~, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(a) At least 75% of the aggregate amount of premiums ~~collected~~earned in the case of group policies, ~~and~~or

(b) At least ~~60~~65% of the aggregate amount of premiums ~~collected~~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.

(2) All filings of rates and rating schedules ~~shall~~must demonstrate that ~~actual and~~ expected ~~losses~~claims in relation to premiums comply with the requirements of this ~~section~~rule~~.~~ when combined with actual experience to date. Filings of rate revisions must also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are

computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) ~~Every entity providing medicare supplement policies in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the foregoing applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principals and experience.~~ For purposes of applying ARM 6.6.510 and NEW RULE III only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) must be the same as group policies.

~~(4) For the purposes of this rule, policy forms shall be deemed to comply with the loss ratio standards if:~~

~~(a) for the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates that have been in force for 3 years or more is greater than or equal to the applicable percentages contained in this rule; and~~

~~(b) the expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this rule. An expected third year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.~~

(~~5~~4) As soon as practicable, but prior to the effective date of enhancements in medicare ~~benefit changes~~ benefits, every ~~insurer, health care service plan or other entity~~issuer ~~providing~~ of medicare supplement ~~insurance or contracts~~ policies or certificates in this state, ~~shall~~must file with the commissioner, in accordance with the applicable filing procedures of this state:

(a) Appropriate premium adjustments necessary to produce loss ratios as ~~originally~~ anticipated for the current premium for the applicable policies or ~~contracts~~certificates. Such supporting documents as necessary to justify the adjustment ~~shall~~must accompany the filing~~, and~~.

~~(b) Every insurer, health care service plan or other entity providing medicare supplement insurance or benefits to a resident of this state~~ An issuer ~~shall~~must make such premium adjustments as are necessary to produce an expected loss ratio under such policy or ~~contract~~certificate as will conform with minimum loss ratio standards for medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the ~~insurer, health care service plan or other entity~~ issuer for such medicare supplement ~~insurance~~ policies or ~~contracts~~certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(i) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(b) Any appropriate riders, endorsements or policy forms needed to accomplish the medicare supplement ~~insurance~~policy or certificate modifications necessary to eliminate benefit duplications with medicare. ~~Any~~Such riders, endorsements or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or ~~contract~~certificate.

(5) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A to this rule for each type in a standard medicare supplement benefit plan.

(6) 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 must be done on a statewide basis for each type in a standard medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

~~(6) For purposes of this section, medicare supplement policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, must be treated as individual policies.~~

(7) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(8) An issuer of medicare supplement policies and certificates issued before or after the effective date of these rules in this state must file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner, demonstrating that it is in compliance with the foregoing. The supporting documentation must also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration must exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

(9) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. Any such determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

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

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE_____ SMSBP[1] _____

For the State of_____ Company Name_____

NAIC Group Code_____ NAIC Company Code_____

Address_____ Person Completing Exhibit_____

Title_____ Telephone Number_____

line		(a) Earned Premium[2]	(b) Incurred Claims[3]
1.	Current Year's Experience a. Total (all policy years) b. Current year's issues[4] C. Net (for reporting purposes = 1a - 1b)	_____	_____
2.	Past Years' Experience (All Policy Years)	_____	_____
3.	Total Experience (Net Current Year + Past Year's (Experience)	_____	_____
4.	Refunds Last Year (Excluding Interest) _____		
5.	Previous Since Inception (Excluding Interest) _____		
6.	Refunds Since Inception (Excluding Interest) _____		
7.	Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1) _____		
8.	Experienced Ratio Since Inception _____ Total Actual Incurred Claims (line 3, col. b) = Ratio 2 --- Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception _____		

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life 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.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE_____ SMSBP[1] _____

For the State of_____ Company Name_____

NAIC Group Code_____ NAIC Company Code_____

Address_____ Person Completing Exhibit_____

Title_____ Telephone Number_____

11. Adjustment to Incurred Claims for Credibility _____

Ratio 3 = Ratio 2 + Tolerance

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

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

12. Adjusted Incurred Claims _____

[Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)] X Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col. a) -
Refunds Since Inception (line 6) -

Adjusted Incurred Claims (line 12)

Benchmark Ratio (Ratio 1) _____

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

[1] "SMSBP" = Standardized Medicare Supplement Benefit Plan
[2] Includes Modal Loadings and Fees Charged
[3] Excludes Active Life Reserves
[4] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios".

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

_____
Signature

_____
Name - Please Type

_____
Title

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR_____

TYPE_____ SMSBP (p)_____

FOR THE STATE OF_____

Company Name_____

NAIC Group Code_____ NAIC Company Code_____

Address_____

Person Completing This Exhibit_____

Title_____ Telephone Number_____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.61
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2 (etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989, etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

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

(a) An issuer's name must be as prominently displayed as the name of the association, tradename, or other sponsoring organization.

(b) The policy and certificate must be identified by the proper plan designation.

(2) An issuer shall not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures by the commissioner.

(3) Except as provided in (2), 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.

(a) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, one for each of the following cases:

(i) the inclusion of new or innovative benefits;

(ii) the addition of either direct response or agent marketing methods;

(iii) the addition of either guaranteed issue or underwritten coverage;

(iv) the offering of coverage to individuals eligible for medicare by reason of disability.

(b) For the purposes of this rule, a "type" means an individual policy or a group policy.

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

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

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to (4) shall not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five 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) The sale or other transfer of medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(d) A change in the rating structure or methodology shall be considered a discontinuance under (1) unless the issuer complies with the following requirements:

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

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

(5) Except as provided in (2), the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in ARM 6.6.508.

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

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

6.6.509 REQUIRED DISCLOSURE PROVISIONS (1) Medicare supplement policies and certificates must include a renewal~~,~~ or continuation~~, or nonrenewal~~ provision. The language or specifications of the provision must be consistent with the type of contract to be issued. The provision must be appropriately captioned, ~~and shall~~must appear on the first page of the policy, ~~and must clearly state the duration of renewability, if limited, and the duration of the term of coverage for which the policy is issued and for which it may be renewed~~and must include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the ~~insurer~~ issuer effectuates a request made in writing by the insured or exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing and signed by the insured, unless the increased benefits or coverage are

required by the minimum standards for medicare supplement ~~insurance~~ policies, or if the increased benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy.

(3) A Medicare supplement policy~~ies or certificates~~ ~~that~~ must not provide~~s~~ for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import ~~must include a definition and an explanation of the terms in its accompanying outline of coverage~~.

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

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

(6) ~~Insurers issuing~~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, other than incidentally, to persons eligible for medicare by reason of age must provide to ~~all~~ such applicants a medicare supplement "buyer's guide". This may be ~~the "buyer's guide" required to be provided is 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 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. 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. Delivery of the "buyer's guide" must be made whether or not such policies or certificates ~~or subscriber contracts~~ are advertised, solicited, or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response ~~insurers~~, issuers delivery of the "buyer's guide" must be made to the applicant at the time of application and acknowledgment of receipt of the "buyer's guide" must be obtained by the ~~insurer~~issuer. Direct response ~~insurers~~issuers must deliver the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered.

~~(7) Except as otherwise provided in ARM 6.6.509(9), the terms "medicare supplement", "Medigap", and words of similar~~

~~import must not be used unless the policy is issued in compliance with ARM 6.6.507.~~

~~(8) The following notice requirements apply to all insurers, health care service plans or other entities providing medicare supplement insurance:~~

(a7) As soon as practicable, but no later than 30 days prior to the annual effective date of any medicare benefit changes, ~~every insurer, health care service plan or other entity~~an issuer ~~providing medicare supplement insurance or benefits to a resident of this state~~shall notify its policyholders~~, contract holders~~ and certificateholders of modifications it has made to medicare supplement insurance policies or ~~contracts~~certificates in a format acceptable to the commissioner~~or in the format prescribed in appendix A if no other format is prescribed by the commissioner~~. Such notice ~~shall~~must:

(a) include a description of revisions to the medicare program and a description of each modification made to the coverage provided under the medicare supplement ~~insurance~~ policy or ~~contract~~certificate; and

(b) inform each ~~covered person~~policyholder or certificateholder as to when any premium adjustment is to be made due to changes in medicare.

(c) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and ~~simple~~concise terms so as to facilitate comprehension.

(d) Such notices ~~shall~~must not contain, or be accompanied by, any solicitation.

~~(9) Insurers must provide an outline of coverage for medicare supplement policies, as provided below:~~

(a8) ~~Insurers issuing~~Issuers ~~medicare supplement policies for delivery in this state must~~shall provide an outline of coverage to each applicant at the time application is ~~made~~ presented to the prospective applicant and, except for direct response policies, ~~must~~shall obtain an acknowledgment of receipt of such outline from the applicant;

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

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

(e~~b~~) The outline of coverage provided to applicants ~~pursuant to subsection (a) must be in the form prescribed in ARM 6.6.511, sample form A~~consists of four parts: 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 shall be shown on the cover page, and the plan(s) 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:
Benefit Plan(s) _____(insert letter(s) of plan(s) being offered)

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

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

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

(~~10~~2) Any accident and sickness insurance policy or ~~subscriber contract~~certificate, other than a medicare supplement policy; or a policy issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in ARM 6.6.503(2) issued for delivery in this state to persons eligible for medicare by reason of age must be accompanied by a notice to the insureds under the policy ~~or subscriber contract~~ that the policy ~~or subscriber contract~~ is not a medicare supplement policy or certificate. The notice must either be printed on or attached to the first page of the outline of coverage delivered to insureds under the policy ~~or subscriber contract~~, or if no outline of coverage is delivered, to the first page of the policy or certificate~~, or subscriber contract~~ delivered to insureds. The notice must be in no less than 12 point type and must contain the following language: "THIS (POLICY~~,~~ OR CERTIFICATE~~, OR SUBSCRIBER CONTRACT~~) IS NOT A medicare SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for medicare, review the medicare Supplement Buyers Guide available from the company."

~~(11) Insurers must preserve any signed acceptance or acknowledgment required under this rule for three years.~~

AUTH: 33-1-313, MCA IMP: 33-22-907, MCA

6.6.510 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE (1) Application forms must include questions designed to elicit information as to whether, as of the date of application, the applicant has another medicare supplement or 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~~, except where coverage is sold without a producer,~~ containing such questions and statements as the following may be used~~:~~

(STATEMENTS)

You do not need more than one medicare supplement policy.

If you are 65 or older, you may be eligible for benefits under medicaid and may not need a medicare supplement policy.

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

Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning medicaid.

(QUESTIONS)

To the best of your knowledge:

(a1) Do you have another medicare supplement ~~insurance~~ policy or certificate in force (including health care service contract, health maintenance contract)?

~~(b) Did you have another medicare supplement policy or certificate in force during the last 12 months?~~

~~(i) If so, with which company?~~

~~(ii) If that policy lapsed, when did it lapse?~~

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

If so, with which company?

What kind of policy?

If the answer to question (1) or (2) is yes, do you intend to replace these medical or health policies with this policy (certificate)?

~~(c)~~ Are you covered by medicaid?

~~(d) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate).~~

(2) Producers shall list any other health insurance policies they have sold to the applicant, including:

(a) Policies sold which are still in force.

(b) Policies sold in the past ~~5~~five years which are no longer in force.

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

(~~3~~4) Upon determining that a sale will involve replacement of medicare supplement coverage, and prior to the issuance or delivery of the medicare supplement policy or certificate, an ~~insurer~~issuer, other than a direct response insurer, or its producer must furnish the applicant a notice regarding replacement of ~~accident and sickness~~medicare supplement coverage. One copy of the notice signed by the applicant and the producer, except where coverage is sold without a producer, must be provided to the applicant and an additional signed copy must be retained by the ~~insurer~~issuer for three years. A direct response ~~insurer~~issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of ~~accident and sickness~~medicare supplement coverage. ~~In no event, however, will such notice be required in the solicitation of "accident only" and "single premium nonrenewable" policies.~~

(~~4~~5) The notice required by (~~3~~4) ~~above~~ for an ~~insurer~~issuer~~, other than a direct response insurer,~~ must be in substantially the same form ~~prescribed in ARM 6.6.511, sample form B,~~as below and be in no less than 10 point type.

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT
INSURANCE

(Insurance Company's Name and Address)

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide 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 coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, OR PRODUCER:

(I have reviewed your current medical or health insurance coverage. 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)

(1) 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) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy as long as you have not allowed your policy to lapse for over 31 days.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium

as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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

_____

(Signature of Producer or Other Representative)*

[Typed Name and Address of Issuer or Producer]

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

*Signature not required for direct response sales.

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

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

6.6.511 ~~SAMPLE FORMS~~SAMPLE FORMS OUTLINING COVERAGE

(1) The following are sample forms of the outline of coverage ~~and notices regarding replacement of~~for medicare supplement policies:

~~(1) Sample Form A - outline of coverage:~~

~~(COMPANY NAME)~~

~~OUTLINE OF MEDICARE~~

~~SUPPLEMENT COVERAGE~~

~~(1) Read your Policy* Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!~~

~~*The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate~~

~~(2) Medicare Supplement Coverage. Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine (delete of such coverage is provided).~~

~~(3) (a) (for agents)~~

~~Neither (insert company's name) nor its agents are connected with Medicare.~~

~~(b) (for direct responses:)~~

~~(insert company's name) is not connected with Medicare.~~

~~(4) (A brief summary of the major benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, provided by the medicare supplement coverage in the following order:)~~

~~DESCRIPTION~~	~~THIS POLICY PAYS**~~	~~YOU PAY~~
~~1. Minimum Standards~~		
~~SERVICE~~		
~~PART A~~		
~~INPATIENT HOSPITAL SERVICES~~		
~~Semi-Private Room & Board~~		
~~Miscellaneous Hospital Services & Supplies such as Drugs, X-Rays, Lab Tests & Operating Room~~		
~~BLOOD~~		
~~PART B~~		

~~MEDICAL EXPENSE~~

~~Services of a Physician Outpatient Service~~

~~Medical Supplies other than Prescribed Drugs~~

~~BLOOD~~

~~MISCELLANEOUS~~

~~Immunosuppressive Drugs~~

* *

~~II. Additional Benefits~~

~~PART A~~

~~Part A Deductible~~

~~Private Rooms~~

~~In-Hospital Private Nurses~~

~~Skilled Nursing Facility Care~~

~~PARTS A & B~~

~~Home Health Services~~

~~PART B~~

~~Part B Deductible~~

~~Medical Charges in Excess of Medicare Allowable Expenses (Percentage Paid)~~

~~OUT-OF-POCKET MAXIMUM~~

~~PRESCRIPTION DRUGS~~

~~MISCELLANEOUS~~

~~Respite Care Benefits~~

~~Expenses incurred in Foreign Country~~

~~Other~~

~~TOTAL PREMIUM ———————————— $————————~~

~~IN ADDITION TO THIS OUTLINE OF COVERAGE, [insurance company name] will send an annual notice to you 30 days prior to the effective date of medicare changes which will describe these changes and the changes in your medicare supplement coverage.~~

~~**If this policy does not provide coverage for a benefit listed above, the insurer must state no coverage besides that benefit in the first column.~~

~~(5) The following charts shall accompany the outline of coverage:~~

~~[COMPANY NAME]~~
~~NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE — 1990~~

~~THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!~~

~~[A BRIEF DESCRIPTION OF THE REVISION TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.]~~

~~SERVICES~~	~~MEDICARE BENEFITS~~		~~YOUR MEDICARE SUPPLEMENT COVERAGE~~
	~~In 1989 Medicare Pays Per Calendar Year~~	~~Effective January 1, 1990, Medicare Will Pay~~	~~In 1989 Your Coverage Pays~~	~~Effective January 1, 1990 Your Coverage Will Pay~~
~~MEDICARE PART A SERVICES AND SUPPLIES~~				
~~Inpatient Hospital Services~~	~~$560 deductible~~	~~Unlimited number of hospital days after 60 days/benefit period~~	~~All but $592 for first~~	

~~Semi-Private Room & Board~~	~~All but $148 a day for 61st-90th days/benefit period~~	
~~Misc. Hospital Services & Supplies such as Drugs, X-Rays, Lab Tests & Operating Room~~	~~All but $296 a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)~~	
~~BLOOD~~	~~Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B~~	~~Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each calendar year~~

~~SERVICES~~	~~MEDICARE BENEFITS~~		~~YOUR MEDICARE SUPPLEMENT COVERAGE~~
	~~In 1989 Medicare Pays Per Calendar Year~~	~~Effective January 1, 1990, Medicare Will Pay~~	~~In 1989 Your Coverage Pays~~ ~~Effective January 1, 1990 Your Coverage Will Pay~~
~~SKILLED NURSING FACILITY CARE~~	~~There is no prior confinement requirement for this benefit~~	~~100% of costs for 20 days (after a 3 day prior hospital confinement.) /benefit period~~	

	First 8 days - All but $25.50 a day	All but $74.00 a day for 21st - 100th days/ benefit period	
	9th through 150th day - 100% of costs	Beyond 100 days - Nothing/ benefit period	
	Beyond 150 days - Nothing		
MEDICARE SERVICES AND SUPPLIES	80% of allowable charges (after $75 deductible)	80% of allowable charges (after $75 deductible/ calendar year)	charges
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year)	Inpatient
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $75 deductible/ calendar year)	

~~(after $75 deductible/ calendar year)~~

~~[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.]~~

~~[Describe any coverage provisions changing due to Medicare modifications.]~~

~~[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]~~

~~THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY [COMPANY] ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT [Policy] CONTACT:~~

~~[COMPANY OR FOR AN INDIVIDUAL POLICY NAME OF PRODUCER][ADDRESS/PHONE NUMBER]~~

~~(6) (Statement that the policy does or does not cover the following:)~~

~~(a) Private duty nursing,~~

~~(b) Skilled nursing home care costs (beyond what is covered by Medicare),~~

~~(c) Custodial nursing home care costs,~~

~~(d) Intermediate nursing home care costs,~~

~~(e) Home health care above number of visits covered by Medicare,~~

~~(f) Physician charges (above Medicare's reasonable charge),~~

~~(g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay),~~

~~(h) Care received outside of U.S.A.,~~

~~(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.~~

~~(7) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements;)~~

~~(a) (That the chart summarizing Medicare benefits only briefly describes such benefits.)~~

~~(b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)~~

~~(8) (A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.)~~

~~(9) (The amount of premium for this policy.)~~

~~(2) Sample Form B. Notice Regarding Replacement.~~

~~(To be used by an insurer other than a direct response insurer.)~~

~~NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE~~

~~(Insurance Company's Name and Address)~~

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

~~According to (your application), (information you have furnished), you intend to lapse or otherwise terminate existing Medicare supplement insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.~~

~~You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.~~

~~STATEMENT TO APPLICANT BY PRODUCER: (Use additional sheets, as necessary.)~~

~~I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:~~

~~(1) 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) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy as long as you have not allowed your policy to lapse for over 31 days.~~

~~(3) If you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~

~~(4) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.~~

~~(Signature of Producer or Other Representative)~~

~~The above "Notice to Applicant" was delivered to me on:~~

~~(Date)~~

~~(Applicant's Signature)~~

~~(3) Sample form C Notice Regarding Replacement. (To be used by a direct response insurer.)~~

~~NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE~~

~~(Insurance Company's Name and Address)~~

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

~~According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing Medicare supplement insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.~~

~~You should review this new coverage carefully, comparing it with all accident and sickness coverage you now have, and terminate your present policy only if, after due consideration, you find~~

~~that purchase of this medicare supplement coverage is a wise decision.~~

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

~~(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy as long as you have not allowed your policy to lapse for over 31 days.~~

~~(3) If you are replacing existing Medicare supplement insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~

~~(4) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.~~

~~(Company name)~~

~~(History: Sec. 33-1-313, 33-22-904 and 33-22-907, MCA; IMP, 33-15-303 & 33-22-901 through 33-22-924, MCA; NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90.)~~

(a) **COVER PAGE**

PREMIUM INFORMATION [boldface type]

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

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [boldface type]

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

RIGHT TO RETURN POLICY [boldface type]

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

POLICY REPLACEMENT [boldface type]

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

NOTICE [boldface type]

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

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

[for direct response:]
[insert company's name] is not connected with medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, medicare payments, plan payments and insured payments for each plan, using the same language in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to section 9D of this regulation.]

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

(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 $[676]	$0	$[676] (Part A deductible)
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] 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 [$84.50]/day	$0	Up to $[84.50] 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

PLAN A

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

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

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[676]	$[676] (Part A deductible)	$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible	
---Additional 365 days	$0	expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$84.50]/day	$0	Up to $[84.50] 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

PLAN B

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

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

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

PARTS A & B

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

(3)

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 $[676]	$[676] (Part A deductible)	$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible	
---Additional 365 days	$0	expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$84.50]/day	Up to $[84.50] 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

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
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 - 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 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 $[676]	$[676] (Part A deductible)	$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] a day $0	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$84.50]/day	Up to $[84.50] 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

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
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

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies		$[676] (Part A deductible)	
First 60 days	All but $[676]		$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] 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 [$84.50]/day	Up to $[84.50] 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

PLAN E

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

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

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

PARTS A & B

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

PLAN 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 Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

(c)

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[676]	$[676] (Part A deductible)	$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible	
---Additional 365 days	$0	expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$84.50]/day	Up to $[84.50] 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

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.

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	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

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 F

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(h)

PLAN 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 $[676]	$[676] (Part A deductible)	$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] 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 [$84.50]/day	Up to $[84.50] 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

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	80%	20%
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 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
---Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

(1)

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 $[676]	$[676] (Part A deductible)	$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] 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 [$84.50]/day	Up to $[84.50] 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

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
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

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	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
		80% to a lifetime maximum benefit	20% and amounts over the $50,000 life-
Remainder of charges	$0	of $50,000	time maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
		50% - $1,250	
Next $2,500 each calendar year	$0	calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

(1)

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 $[676]	$[676] (Part A deductible)	$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible	
---Additional 365 days	$0	expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$84.50]/day	Up to $[84.50] 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

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
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

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

PLAN I

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[676]	$[676] (Part A deductible)	$0
61st thru 90th day	All but $[169] a day	$[169] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[338] a day	$[338] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible	
---Additional 365 days	$0	expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$84.50]/day	Up to $[84.50] 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

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.

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	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 J

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	$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	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN J

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

AUTH: 3-1-313, MCA IMP: 33-22-904, MCA; and 33-22-907, MCA

6.6.515 STANDARDS FOR CLAIMS PAYMENT (1) ~~Every entity providing medicare supplement policies or contracts~~An issuer ~~must~~shall comply with ~~all provisions of section 4081 of the Omnibus Budget Reconciliation Act of 1987(P. L. 100-203),~~ section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203) by:

(a) Accepting a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(c) Paying the participating physician or supplier directly;

(d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(f) Providing to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

(2) Compliance with the above requirements ~~set forth in subsection (1) above~~ must be certified on the medicare supplement insurance experience reporting form.

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

6.6.517 PERMITTED COMPENSATION ARRANGEMENTS (1) An ~~insurer~~issuer or other entity may provide commission or other compensation to a producer ~~or other representative~~ for the sale of a medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

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

(3) No issuer or other entity shall provide compensation to its producers ~~or other representatives~~ and no producer ~~or other representative~~ shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies or certificates if an existing policy or certificate is replaced unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy.

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

(5) As part of the annual filing under ARM 6.6.508(3), ~~of this rule~~ the entity providing medicare supplement policies shall provide copies of commission schedules.

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

6.6.519 STANDARDS FOR MARKETING (1) ~~Every insurer, health care service plan or other entity marketing medicare supplement insurance coverage in this state~~An issuer, ~~directly or through its producers,~~ shall:

(a) Establish marketing procedures to assure that any comparison of policies by its producers ~~or other representatives~~ will be fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) Establish marketing procedures which set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy for purposes of triggering first year commissions as authorized in ARM 6.6.517.

(d) Display prominently by type, stamp or other appropriate means, on the first page of the ~~outline of coverage and~~ policy the following: "Notice to buyer: This policy may not cover all of ~~the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations~~your medical expenses."

(e) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(f) ~~Every insurer or entity marketing medicare supplement insurance shall e~~Establish auditable procedures for verifying compliance with ~~subsection (1)~~ this rule.

(2) In addition to the practices prohibited in Title 33, chapter 18, MCA, the following acts and practices are prohibited:

(a) ~~Twisting.~~ Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance ~~in~~with another insurer.

(b) ~~High pressure tactics.~~ Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(c) ~~Cold lead advertising.~~ Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurer producer or insurance company.

(3) The terms "medigap," "medicare wrap-around" and words of similar import must not be used.

AUTH: 33-1-313, MCA; and 33-18-235, MCA IMP: 33-22-904, MCA; and 33-18-235, MCA

6.6.520 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE (1) In recommending the purchase or replacement of any medicare supplement policy or certificate, an insurance producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of medicare supplement coverage ~~which~~that will provide an individual more than one medicare supplement policy or certificate is prohibited~~; provided, however, that additional medicare supplement coverage may be sold if, when combined with that individual's health coverage already in force, it would insure no more than 100% of the individual's actual medical expenses covered under the combined policies~~.

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

6.6.521 REPORTING OF MULTIPLE POLICIES (1) On or before March 1 of each year, every ~~insurer or other entity providing~~issuer ~~medicare supplement insurance coverage in this state~~ shall report the following information for every individual resident of this state for which the ~~insurer or entity~~issuer has in force more than one medicare supplement insurance policy or certificate:

(a) policy and certificate number; and

(b) date of issuance.

(2) The items set forth above must be grouped by individual policyholder.

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

6.6.522 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES (1) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing ~~insurer~~issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new medicare supplement policy ~~for similar benefits~~ to the extent such time was spent under the original policy.

(2) If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy must not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

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

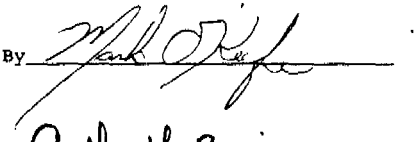
REASON: These rule revisions are being proposed because they are mandated by Chapter 163, Laws of 1993, which, in turn, meets the requirements of 42 U.S.C. 1395 ss(p)(1)(A). The revisions will make these rules uniform with those of other states.

6. Interested 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 Frank Cote, Deputy Commissioner of Insurance, P.O. Box 4009, Helena, Montana 59604, and must be received no later than June 28, 1993.

7. The State Auditor will make reasonable accommodations for persons with disabilities who wish to participate at this public hearing. If you request an accommodation, please contact the State Auditor's Office not later than 5:00 p.m., June 14, 1993, and advise the office of the nature of the accommodation needed. Please contact Frank Cote, Deputy Commissioner of Insurance, P.O. Box 4009, Helena, Montana 59604; telephone (406) 444-5237; toll free dial 1 and then 800-332-6148; fax (406) 444-3497.

8. Geoffrey L. Brazier, 516 Harrison Avenue, Helena, Montana 59601, has been designated to preside over and conduct the hearing.

MARK O'KEEFE, State Auditor
and Commissioner of Insurance

By 

Geoffrey L. Brazier
Rules Reviewer

Certified to the Secretary of State this 17th day of May, 1993.

BEFORE THE BOARD OF ALTERNATIVE HEALTH CARE
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to fees, licensing by examination, and direct entry midwife apprenticeship requirements and the adoption of new rules pertaining to unprofessional conduct, high risk conditions, consultation or transfer conditions, and required reporting	NOTICE OF PROPOSED AMENDMENT OF 8.4.301 FEES, 8.4.501 LICENSING BY EXAMINATION, AND 8.4.503 DIRECT ENTRY MIDWIFE APPRENTICESHIP REQUIREMENTS AND THE ADOPTION OF NEW RULES PERTAINING TO UNPROFESSIONAL CONDUCT, HIGH RISK CONDITIONS, CONSULTATION OR TRANSFER CONDITIONS, AND REQUIRED REPORTING

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On June 26, 1993, the Board of Alternative Health Care proposes to amend the above-stated rules.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.4.301 FEES (1) Fees shall be transmitted by check payable to the board of alternative health care. The board assumes no responsibility for loss in transit of such remittances. Applicants not submitting the proper fees will be notified by the department. Fees are non-refundable.

(2) through (2)(n) will remain the same."

Auth: Sec. 37-26-201, 37-27-105, MCA; IMP, Sec. 37-26-201, 37-27-205, 37-27-210, MCA

REASON: The proposed amendment will implement changes mandated by the 1993 Legislature and allow the Board to retain fees to cover costs of processing applications.

"8.4.501 LICENSING BY EXAMINATION (1) through (1)(b) will remain the same.

(c) a GED or other high school equivalency program certificate of completion; or

(c) will remain the same but will be renumbered (d).

(i) documentation of fifteen continuous care births must show at least 5 prenatal visits beginning on or before the 28th week of gestation, and include one post-natal visit. Ten of the fifteen continuous care births must have occurred under the personal supervision of a qualified supervisor.

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

(b) achieve a passing score of ~~70~~ 75 percent~~, as required by statute~~.

(3) will remain the same."

Auth: Sec. 37-27-105, MCA; IMP, Sec. 37-27-201, 37-27-202, 37-27-203, MCA

REASON: The proposed amendments will implement changes mandated by the 1993 Legislature. The amendments will allow high school equivalency degrees for applicants who have completed these programs, and will set the 75% passing score recommended by the national examination organization. The amendment will also clarify the number and timing of prenatal visits so applicants may ensure their experience will meet the requirements.

"8.4.503 DIRECT ENTRY MIDWIFE APPRENTICESHIP REQUIREMENTS (1) and (2) will remain the same.

(a) name of supervisor who shall be a licensed direct entry midwife, a certified nurse midwife, a licensed naturopathic physician who is certified for the specialty practice of childbirth attendance, or a physician licensed under Title 37, chapter 3;

(b) and (c) will remain the same.

(i) A waiver will allow an individual supervisor to supervise up to four direct entry midwife apprentices at the same time from the date of adoption of these rules until ~~September 1, 1993~~ September 1, 1997.

(3) through (4) will remain the same.

(5) A level III direct entry midwife apprenticeship is served under the personal supervision of the licensed supervisor or under indirect supervision, as defined by board rules, at the discretion of the supervisor. However, in order to meet the 10 personally supervised continuous care birth requirement of 8.4.501, indirect supervision will only be approved by the board after this requirement has been met. A formal outline of indirect supervision communication shall be submitted in writing to the board for approval, prior to implementation, which shall include supervisor chart review, and may include telephone contact supervision. The focus of level III shall be continuous prenatal, perinatal and postnatal care. To complete level III, the direct entry midwife apprentice shall:

(a) will remain the same.

(i) documentation of fifteen continuous care births must show at least 5 prenatal visits beginning on or before the 28th week of gestation, and include one post-natal visit. Ten of the fifteen continuous care births must have occurred under the personal supervision of a qualified supervisor.

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

(a) documentation of fifteen continuous care births must show at least 5 prenatal visits beginning on or before the 28th week of gestation, and include one post-natal visit. Ten of the fifteen continuous care births must have occurred under the personal supervision of a qualified supervisor.

(7) will remain the same.

(a) be currently licensed in good standing as a direct entry midwife, a certified nurse midwife, a licensed naturopathic physician who is certified for the specialty practice of naturopathic childbirth attendance, or a physician licensed under Title 37, chapter 3, MCA. A licensed direct entry midwife supervisor shall have been licensed for ~~two~~ one years and have 20 continuous care births as primary attendant,

before becoming a supervisor, except for those licensees who have successfully passed the first licensing exam administered by the board;

(b) through (e) will remain the same."

Auth: Sec. 37-27-105, MCA; IMP, Sec. 37-27-201, 37-27-205, 37-27-210, 37-27-213, 37-27-321, MCA

REASON: The proposed amendments will implement changes mandated by the 1993 Legislature and allow a naturopathic physician with a specialty certificate to supervise apprentice lay midwives so more supervisors are available for apprentice applicants. The amendments will also clarify the number and timing of prenatal visits for apprentice applicant requirements also.

3. The proposed new rules will read as follows:

"I UNPROFESSIONAL CONDUCT For the purposes of implementing the provisions of section 37-26-408 and 37-27-213, MCA, the board defines unprofessional conduct for naturopathy and midwifery as follows:

(1) Any act involving moral turpitude, dishonesty or corruption relating to the practice of naturopathy or midwifery whether the act constitutes a crime or not. If the act constitutes a crime, conviction in a criminal proceeding is not a condition precedent to disciplinary action. Upon such a conviction, however, the judgement and sentence is conclusive evidence at the ensuing disciplinary hearing of the guilt of the licensee or applicant of the crime described in the indictment or information, and of the person's violation of the statute on which it is based. For the purpose of this section, conviction includes all instances in which a plea of guilty is the basis for the conviction and all proceedings in which the sentence has been deferred or suspended;

(2) Violation of any state or federal statute or administrative rule regulating the practice of naturopathy or midwifery;

(3) Advertising which is false, fraudulent or misleading;

(4) Resorting to fraud, misrepresentation or deception in the examination or treatment of a patient or in billing or reporting to a person, company, institution or agency;

(5) Incompetence, negligence or use of any procedure in the practice of naturopathy or midwifery which creates an unreasonable risk of physical harm or serious financial loss to the patient;

(6) Malpractice, or an act or acts falling below the generally accepted standard of care for naturopathy or midwifery whether actual harm was suffered by any patient;

(7) Suspension, revocation, or restriction of the individual's license to practice naturopathy or midwifery by competent authority in any state, federal, or foreign jurisdiction for reasons that would be grounds for disciplinary sanction in this jurisdiction, a certified copy of the order or agreement being conclusive evidence of the revocation, suspension or restriction;

(8) Possession, use, addiction to, diversion or distribution of controlled substances or legend drugs in any way other than legitimate use, or violation of any drug law;

(9) Failing to cooperate with an investigation authorized by the Board of Alternative Health Care by:

(a) not furnishing any papers or documents in the possession of and under the control of the license holder;

(b) not furnishing in writing a full and complete explanation covering the matter contained in the complaint; or

(c) not responding to subpoenas issued by the board or the department, whether or not the recipient of the subpoena is the accused in the proceedings;

(10) Interfering with an investigation or disciplinary proceeding by willful misrepresentation of the facts or by the use of threats or harassment against any client or witness to prevent them from providing evidence in a disciplinary proceeding or any other legal action;

(11) Failure to comply with an order issued by the Board;

(12) Practice beyond the scope of practice encompassed by the license;

(13) Failing to maintain appropriate records as specified in statute or in the rules of the board;

(14) Failing to adequately supervise auxiliary staff to the extent that the patient's physical health or safety is at risk;

(15) Aiding or abetting an unlicensed person to practice when a license is required;

(16) Practicing naturopathy or midwifery while the license is suspended, revoked or not currently renewed;

(17) Willful or repeated violations of rules established by any health agency or authority of the state or a political subdivision thereof;

(18) Engaging in the practice of naturopathy or midwifery while suffering from a contagious or infectious disease creating a serious risk to public health;

(19) The willful betrayal of a practitioner-patient privilege as provided by law;

(20) offering, undertaking, or agreeing to cure or treat disease or affliction by a secret method, procedure, treatment, or the treating, operating, or prescribing for any health condition by a method, means, or procedure which the licensee refuses to divulge upon demand from the board;

(21) Abandoning, neglecting, or otherwise physically or emotionally abusing a client or patient requiring care;

(22) Intentionally or negligently causing physical or emotional injury or abuse to a client or patient, or sexual contact with a client or patient in a clinical setting;

(23) Operating under unsanitary conditions after a warning from the board or consistently maintaining an unsanitary office;

(24) Failure to file reports required in the board's statutes or rules;

(25) Failure by a midwife to maintain a current and valid CPR card."

Auth: Sec. 37-26-201, 37-27-105, MCA; IMP, Sec. 37-26-201, 37-26-408, 37-27-105, 37-27-213, MCA.

REASON: The proposed new rule will establish unprofessional conduct standards for licensees as required by disciplinary statutes, and allow licensees to be informed as to the types of conduct which will be grounds for disciplinary action by the board.

"II HIGH RISK PREGNANCY; CONDITIONS REQUIRING PRIMARY CARE BY A PHYSICIAN (1) If the following conditions are present, the licensed direct entry midwife shall not accept the woman as a client:

(a) Chronic medical problems:

(i) cardiac disease (Class II or greater);

(ii) diabetes mellitus (Class II or greater);

(iii) essential hypertension (greater than 140/90 Hg);

(iv) hemoglobinopathies;

(v) severe chronic anemia (hemoglobin less than 10 percent, hematocrit less than 30 percent, unresponsive to treatment);

(vi) renal disease (chronic, diagnosed, not urinary tract infection);

(vii) thrombophlebitis or pulmonary embolism;

(viii) epilepsy currently on medication;

(ix) current severe psychiatric condition requiring medication within a six month period prior to pregnancy;

(x) active: tuberculosis, syphilis, gonorrhea, hepatitis, AIDS, genital herpes at onset of labor;

(xi) current drug or alcohol abuse/dependency;

(xii) current malignant disease;

(xiii) chronic obstructive pulmonary disease, except for controlled asthma.

(b) Current pregnancy related conditions:

(i) pregnancy induced hypertension (pre-eclamptic or eclamptic symptoms);

(ii) premature labor (before 36 1/2 weeks gestation verified estimated date of delivery by dates and physical exam;

(iii) placental abruption;

(iv) placenta previa at onset of labor;

(v) has a fetus in any presentation other than vertex at onset of labor;

(vi) gestational diabetes not controlled by diet;

(vii) multiple gestation;

(viii) contracts primary genital herpes in the first trimester.

(c) Previous obstetrical history:

(i) previous Rh sensitization;

(ii) history of inverted uterus.

Auth: Sec. 37-27-105, MCA; IMP, Sec. 37-27-105, MCA

REASON: The proposed new rule will define eligibility criteria for client screening by direct entry midwives to provide midwifery services only to women during low risk pregnancies, as mandated by statute. The rule will allow

licensees to be informed of circumstances under which license discipline may be brought for acceptance of a high risk client.

"III. CONDITIONS WHICH REQUIRE PHYSICIAN CONSULTATION OR TRANSFER OF CARE (1) If the following conditions are present in a client, the direct entry midwife shall consult a physician and/or transfer care to a physician. Documentation of the condition, recommendation and treatment must be maintained in the client records. Conditions include, but are not limited to the following:

(a) Prenatal factors:

(i) severe hyperemes;

(ii) rubella contracted in the first or second trimester;

(iii) maternal anemia (Hemoglobin less than 10, Hematocrit less than 30) unresponsive within one month of treatment;

(iv) oligohydramnios (suspected);

(v) polyhydramnios (suspected);

(vi) premature rupture of membranes at less than 36 1/2 weeks;

(vii) post term greater than 42 1/2 weeks by dates and physical exam;

(viii) large for gestational age (LGA) or small for gestational age (SGA) (suspected);

(ix) Rh sensitization in present pregnancy (not resulting from recent Rhogam);

(x) history of severe postpartum hemorrhage requiring transfusion;

(xi) serious maternal viral/bacterial infection at term;

(xii) blood pressure greater than 140/90 or increase of 30 mm Hg systolic or 15 mm Hg diastolic over baseline, that is unresolved within 30 days;

(xiii) develops signs and symptoms of pre-eclampsia;

(xiv) develops signs and symptoms of gestational diabetes;

(xv) has unresolved vaginitis that requires antibiotic treatment;

(xvi) has unresolved urinary tract infection;

(xvii) continued vaginal bleeding before onset of labor;

(xviii) signs of fetal distress or demise;

(xix) persistent fever;

(xx) history of pre-term delivery (less than 36 1/2 weeks);

(xxi) positive maternal diagnosis of HIV;

(xxii) abnormal Pap smear (Class III or greater);

(xxiii) all condylomas;

(xxiv) grand multiparity;

(xxv) maternal age less than 14 or greater than 40.

(b) Labor, birth risks, and post-partum factors:

(i) significant fetal distress;

(ii) unengaged vertex above -3 station in primipara in active labor;

(iii) fever of 102 degrees Fahrenheit or greater;
(iv) prolonged rupture of membranes (greater than 24 hours with no progress of labor);
(v) thick meconium stained fluid with delivery not imminent;
(vi) severe bleeding prior to or during delivery;
(vii) lack of progress in active labor;
(viii) maternal respiratory distress;
(ix) mother desires consult or transfer;
(x) maternal hemorrhage uncontrolled by IM pitocin;
(xi) third or fourth degree perineal laceration;
(xii) signs of infection;
(xiii) evidence of thrombophlebitis.
(c) Newborn Risk Factors:
(i) less than three vessels in umbilical cord;
(ii) Apgar score less than 7 at 5 minutes;
(iii) fails to urinate or move bowels within 24 hours;
(iv) obvious anomaly;
(v) respiratory distress;
(vi) cardiac irregularities;
(vii) pale cyanotic or gray color;
(viii) abnormal cry;
(ix) jaundice within 24 hours of birth;
(x) signs of prematurity, dysmaturity, or postmaturity;
(xi) lethargic;
(xii) has edema;
(xiii) signs of hypoglycemia;
(xiv) abnormal facial expression;
(xv) abnormal body temperature."
Auth: Sec. 37-27-105, MCA; IMP, Sec. 37-27-105, MCA.

REASON: The proposed new rule will outline the conditions under which a licensee must consult with a physician, or transfer care of a client, but not necessarily refuse to accept the client. The rule will allow licensees to be informed of the circumstances under which license discipline may be brought for failure to consult or transfer.

"IV REQUIRED REPORTS (1) A licensed direct entry midwife shall submit the semiannual summary report on each client, required by 37-27-320, MCA, on January 15 and July 15 of each year.

(2) A licensed direct entry midwife who is supervising a licensed midwife apprentice shall be responsible for filing the statutorily required 72 hour mortality/morbidity report and the semiannual summary report on clients seen by a Level I, II or III apprentice who is not approved for indirect supervision.

(a) A level III apprentice direct entry midwife, approved by the Board for indirect supervision, shall be responsible for filing the statutorily required 72 hour mortality/morbidity report and the semiannual summary report.

(b) Certified nurse midwife, physician, or naturopathic supervisors of an apprentice direct entry midwife shall be responsible to ensure the Level I, II or III (not approved for

indirect supervision) apprentice files the statutorily required 72 hour mortality/morbidity report and the semiannual summary reports."

Auth: Sec. 37-27-105, MCA; IMP, Sec. 37-27-320, MCA.

REASON: The proposed new rule will set dates for receipt of the summary report, and clarify who is to file 72 hour mortality/morbidity reports and summary reports in the supervisor-apprentice setting.

4. Interested persons may present their data, views or arguments concerning the proposed amendments and adoptions in writing to the Board of Alternative Health Care, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., June 24, 1993.

5. If a person who is directly affected by the proposed amendments and adoptions wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Alternative Health Care, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., June 24, 1993.

6. If the Board receives requests for a public hearing on the proposed amendments and adoptions from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendments and adoptions, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 2 based on the 25 licensees in Montana.

BOARD OF ALTERNATIVE HEALTH CARE
MICHAEL BERGKAMP, N.D., CHAIRMAN

BY: Anne M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 17, 1993.

BEFORE THE BOARD OF REALTY REGULATION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to applications, trust accounts, continuing education, and unprofessional conduct, and the proposed adoption of new rules pertaining to property management	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES PERTAINING TO THE PRACTICE OF REAL ESTATE AND THE PROPOSED ADOPTION OF NEW RULES PERTAINING TO PROPERTY MANAGEMENT

TO: All Interested Persons:

1. On June 25, 1993, at 9:00 a.m., a public hearing will be held in the conference room of the Professional and Occupational Licensing Bureau, Lower Level, Arcade Building, 111 North Jackson, Helena, Montana, to consider the proposed amendment of rules pertaining to the practice of real estate and the proposed adoption of rules pertaining to property management.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.58.406A APPLICATION FOR LICENSE--SALESPERSON AND BROKER (1) through (7) will remain the same.

(8) For the broker applicants, the sales and listing experience must be obtained within the previous three (3) years from the date of the Montana broker license application.

(9) Sales or listing of property owned by the applicant, by a corporation, partnership, trust or other entity in which the applicant has an interest, or by such an entity which employed the applicant as an employee, shall not qualify as experience under subsections (2) and (3) above, or under section 37-51-302(2)(c)."

Auth: Sec. 37-1-131, 37-51-203, MCA; IMP, Sec. 37-1-135, 37-51-202, 37-51-302, MCA

"8.58.406C APPLICATION FOR EQUIVALENCY--BROKER (1) will remain the same.

~~(2) For the purpose of determining the section 37-51-302(2)(c), MCA, equivalency qualifications of an applicant who has not been actively engaged as a real estate salesperson for the prescribed period or has not obtained the required listings and sales, equivalent experience may be met by having been, in all other ways, actively engaged as a salesperson:~~

~~(a) for a period of 12 months and having obtained 15 listings and 15 sales in residential real estate or 5 listings and 5 sales in commercial or agricultural real estate; or~~

~~(b) for a period of 36 months and having obtained 5 listings and 5 sales in residential real estate or 3 listings and 3 sales in commercial or agricultural real estate; or~~

~~(c) any appropriate combination of the above. Subsection (2) is advisory only, but may be a correct interpretation of the law.~~

(2) A salesperson who has been actively engaged as a salesperson for a period of 12 months and has obtained 15 listings and 15 sales in residential real estate or 5 listings and 5 sales in commercial or agricultural real estate, or any appropriate combination, shall be considered as having equivalent experience under section 37-51-302, MCA.

(3) A salesperson who has been actively engaged as a salesperson for a period of 36 months and has obtained 5 listings and 5 sales in residential real estate or 3 listings and 3 sales in commercial or agricultural real estate, or any appropriate combination, shall be considered as having equivalent experience under section 37-51-302, MCA.

(3) and (4) will remain the same but will be renumbered (4) and (5)."

Auth: Sec. 37-1-131, 37-51-203, MCA; IMP, Sec. 37-51-202, 37-51-302, MCA

REASON: The amendment to ARM 8.58.406A would clarify that work performed as a salesperson must be conducted within the immediate preceding three years to be credited toward an application for examination as a broker and that the sales and listings so amassed may not include property owned by a corporation, partnership, or trust in which the applicant is a principal.

The proposed amendment to ARM 8.58.406C merely realigns the regulation and makes it easier to understand. There is no change in substance.

"8.58.414 ~~DEPOSITORY~~ TRUST ACCOUNT REQUIREMENTS

(1) Each broker shall maintain a separate bank account which shall be designated a ~~depository~~ trust account wherein all down-payments, earnest money deposits, rent payments, security deposits, or other ~~depository~~ trust funds received by the broker or his salesperson on behalf of a principal, third-party or any other person shall be deposited. Such ~~depository~~ trust accounts may be maintained in interest-bearing accounts with the interest payable to the broker, principal, third-party, or any other person, as may be designated by agreement. Interest payable to the broker shall be identified by agreement as consideration for services performed. Offices or firms having more than one broker, whether broker-owner or broker-associate, may utilize a single ~~depository~~ trust account.

(2) ~~Depository~~ Trust accounts shall be maintained in banks located in Montana.

(3) will remain the same.

(a) The name of such separate account shall be identified by the words "~~depository~~ trust account".

(b) will remain the same.

(c) However, ~~depository~~ trust monies, (with the exception of the broker's commissions) may be disbursed in advance of the termination or consummation of the transaction upon written agreement of the buyers and sellers.

(d) At the client's instructions, ~~depository~~ trust monies may be retained in the ~~depository~~ trust account although there is no purchase, lease or rental agreement in existence or when the transaction has been consummated or terminated.

(4) Each broker shall only deposit ~~depository~~ trust funds received on real estate transactions in his ~~depository~~ trust account and shall not commingle his personal funds or other funds in said ~~depository~~ trust account with the exception that a broker may deposit and keep a sum not to exceed $1000 in said account from his personal funds, including the interest earned on the ~~depository~~ trust account if the ~~depository~~ trust account is maintained in an interest bearing account and the interest accrues to the broker, which sum shall be specifically identified and deposited to cover bank service charges relating to said ~~depository~~ trust account.

(5) A broker may maintain more than one ~~depository~~ trust account.

(6) Each broker shall deposit all real estate money received by him or his salesman in the broker's ~~depository~~ trust account within three business days of receipt of said money by said broker or said salesman unless otherwise provided in the purchase contract, (lease agreement, or rental agreement).

(7) When a broker is registered in the office of the board as in the employ of another broker, the responsibility for the maintenance of a ~~depository~~ trust account shall be the responsibility of the employing broker.

(8) will remain the same.

(9) No payments of personal indebtedness of the broker shall be made from such ~~depository~~ trust account other than a withdrawal of earned commissions payable to such broker or withdrawals made on behalf of the beneficiaries of such ~~depository~~ trust account.

(10) Money held in the ~~depository~~ trust account which is due and payable to the broker must be withdrawn within 5 business days after such money becomes due and payable to the broker.

(11) through (12)(b) will remain the same.

(c) ~~depository~~ trust account checks shall be numbered and all voided checks retained. The checks shall denote the broker's business name, address, and should be designated as "~~depository~~ trust account".

(d) through (13) will remain the same.

(14) The ~~depository~~ trust account must be reconciled monthly except in the case where there has been no activity during that month.

(15) will remain the same.

(16) Each broker shall authorize the board to examine such ~~depository~~ trust account by a duly authorized representative of the board. Such examination shall be made at such time as the board may direct."

Auth: Sec. 37-1-131, 37-51-203, MCA; IMP, Sec. 37-51-202, 37-51-203, MCA

REASON: This rule is being amended to substitute the more readily understood term "trust account" for the existing "depository account." Licensees seem more comfortable with the term "trust account" and the change in terms is not one of substance.

"8.58.415A CONTINUING REAL ESTATE EDUCATION (1) and (2) will remain the same.

~~(3) Two-thirds of the required hours (10) must be in one or more of the following topics: ethics, real estate finance, real estate law and regulation, real estate taxation, consumer protection, risk reduction, agency, contract law, and principles of real estate.~~ By October 1 of each odd numbered year, the board shall prescribe topics in which the 15 hours of education must be obtained. A prescribed combination of required topics will be accepted to fulfill the 15 hours of mandatory education. These topics will concentrate on new and updated information necessary to conduct daily real estate activity for the protection of the public.

(4) and (5) will remain the same.

(6) Proof of successful completion must be submitted to the board with the licensee's renewal application at the conclusion of every two (2) year period, except that inactive licensees shall provide proof of ~~conformance~~ completion at the time of reinstatement in accordance with 8.58.413. ~~No course completion certificates will be accepted by the board at any other time.~~

(7) and (8) will remain the same.

(9) A board representative may audit all board approved courses at no charge for rule compliance.

(10) All approved education must be open and available to all licensees."

Auth: Sec. 37-1-131, 37-51-203, 37-51-204, MCA; IMP, Sec. 37-51-202, 37-51-203, 37-51-204, MCA

REASON: This rule is being amended to clarify board policy in approving courses by allowing auditing of courses to ensure compliance with laws and rules, and by requiring all courses to be open and offered to all licensees to ensure available education to all licensees.

"8.58.415B CONTINUING REAL ESTATE EDUCATION -- COURSE APPROVAL (1) through (3) will remain the same.

~~(4) Approved courses must be real estate industry related and may not include exam "coaching" courses, clerical skills course, motivational courses, sales promotion meetings, trade organization orientation meetings, body language, time management, stress management, and like courses.~~

~~(5)~~ (4) ~~Only 8 hours of credit for approved continuing education correspondence or video courses will be allowed for each requirement period.~~ No credit for continuing education correspondence or video courses will be allowed.

~~(6)~~ (5) ~~Subject to the foregoing, courses previously approved by the board and renewed, courses offered by accredited universities or colleges, courses offered by the national or the Montana association of realtors and their~~

~~affiliates; courses offered by board recognized societies, associations, institutions, and councils; and c~~Courses offered in another states and approved by ~~those~~ that state's real estate licensing body for continuing education, ~~are~~ is recognized and approved."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, 37-51-204, MCA; IMP, Sec. 37-51-202, 37-51-204, MCA

REASON The board has no ability to require examinations for individualized courses and will no longer accept such education without the ability to monitor compliance as required with live courses. The amendment would clarify the out-of-state educational offerings that will be accepted and requiring review of all others, regardless of the sponsor.

"8.58.415C CONTINUING REAL ESTATE EDUCATION -- INSTRUCTOR APPROVAL (1) through (3) will remain the same.

(a) at least a bachelor's degree in a field traditionally associated with the subject matter of real estate transactions and a broker's license or a bachelor's degree in a field traditionally associated with the subject matter of real estate transactions and three years' experience as a licensed salesperson; or

(b) and (4) will remain the same."

Auth: Sec. 37-51-202, 37-51-204, MCA; IMP, Sec. 37-51-202, 37-51-204, MCA

REASON: This proposed amendment requires that an instructor must possess a bachelor's degree in order to be approved to conduct continuing real estate education.

"8.58.419 GROUNDS FOR LICENSE DISCIPLINE - GENERAL PROVISIONS - UNPROFESSIONAL CONDUCT (1) through (3)(a) will remain the same.

(b) Licensees shall disclose in writing to all ~~third~~ parties the existence and nature of the existing agency relationship no later than when an offer is prepared in a transaction.

(c) through (g) will remain the same.

(h) Licensees, in engaging or recommending the services of an attorney, title company, appraiser, escrow agent, or other like person or entity, on behalf of a principal third party, or other person, shall disclose any family relationship, financial relationship and/or financial interest that the licensee or real estate agency with which the licensee is associated may have in that person or entity being engaged or recommended.

(i) through (5) will remain the same."

Auth: Sec. 37-1-131, 37-1-136, 37-51-203, 37-51-321, MCA; IMP, Sec. 37-51-201, 37-51-202, 37-51-321, MCA

REASON: The Board intends that the disclosure of the agency relationship shall be made in writing to all parties to the transaction and that the licensee shall divulge the existence of any family relationship with one party to the other parties in the transaction.

3. The proposed new rules will read as follows:

"I DEFINITIONS The terms used in this chapter shall have their common meaning as used in the property management industry and, unless the content otherwise requires, the following meanings shall also apply:

(1) "salaried employee" means an individual employed by an owner to manage the property of that owner. This term does not include an unlicensed real estate or property management secretary or the holder of a similar position employed to manage many owners' property for a single broker or property manager.

(2) "board" means the board of realty regulation provided in 2-15-1867."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 1, Ch. 142, L. 1993, Sec. 3, Ch. 142, L. 1993

"II APPLICATION FOR LICENSURE (1) An applicant for a property management license must:

(a) submit a completed original application on forms approved by the board and pay the required fees;

(b) submit 3 letters of professional reference from those familiar with the applicant's character;

(c) provide an original copy of a receipt credit report issued within the past six months;

(d) provide the account number and bank name where the property management trust account is held; and

(e) provide a recent 2"x 2"photo of himself or herself.

(2) Real estate licensees wishing to obtain a property management license must make application and pay the required fee without any additional requirements."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 4, Ch. 142, L. 1993

"III APPLICATION FOR EXAMINATION (1) An application for the property management examination must:

(a) be on forms approved by the board and accompanied by the required fees; and

(b) be legible, accurate, and fully completed.

(2) All applications for examination shall remain valid for a period not to exceed 12 months from the date of application. Failure to take the examination within that time will terminate the application. Thereafter the applicant must begin the application process over.

(3) Approval of an application for examination shall not constitute approval of an application for license."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 4, Ch. 142, L. 1993

"IV EXAMINATION (1) Examination schedule information will be available through the board office.

(2) The following rules shall be obeyed by all persons taking an examination, and a disqualification from taking the examination, a finding of lack of good repute, a determination of unsuccessful completion, or a license denial may result from any breach thereof:

(a) examinees may not refer to any notes, books, or memoranda during the course of the examination;

(b) all rough work and calculations must be done on the examination booklet;

(c) the examinees shall not copy questions, make notes of test content, or reveal the contents of examination to others;

(d) examinees will not leave the examination without permission from the examination proctor for any reason until they have handed in the completed answer sheet and test booklet to the administrator of the examination; and

(e) examinees will not attempt to obtain or compare answers by viewing or discussing any matter with another examinee during the course of the examination.

(3) If an applicant for examination fails to take the examination on the date scheduled, he or she must make application in writing to the board or the designated testing entity for rescheduling within 12 months of the date of original application. This application must be accompanied by the rescheduling fee.

(4) The board may from time to time review and amend the examination type, format, and the score upon which the pass or fail determination is made. Prior notice of any amendment will be afforded to all applicants.

(5) A score of 80% shall constitute successful completion of the examination."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 4, Ch. 142, L. 1993

"V PRE-LICENSURE COURSE REQUIREMENTS (1) A property management application must provide evidence of successfully completing a minimum of 20 hours of pre-licensure education approved by the board.

(2) The pre-licensure curriculum must consist of the following topics:

(a) landlord tenant act;
(b) federal and state fair housing laws;
(c) Americans with Disabilities Act;
(d) state licensing law and rules;
(e) trust accounts;
(f) accounting procedures;
(g) definitions;
(h) contract law;
(i) agency; and
(j) leasing principles."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 4, Ch. 142, L. 1993

"VI LICENSE TRANSFER - NOTICE TO THE DEPARTMENT (1) A licensee who changes his or her office location or affiliation must notify the board office in writing within 10 business days of the change. The pocket card and proper fee must accompany such notice. The board office will then issue a corrected pocket card for the remainder of the renewal year."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 6, Ch. 142, L. 1993

"VII LICENSE RENEWAL - LATE RENEWAL (1) Renewal forms will be mailed to all licensed property managers at their last address of record. Failure to receive a renewal form does not eliminate the renewal requirement. Each licensee is required to renew.

(2) Licensees failing to renew their licenses by October 31 of each year may have their licenses reinstated by:

(a) payment of the current renewal fee as prescribed by the board by November 15;

(b) payment of the penalty fee as prescribed by the board;

(c) submission of a completed renewal form; and

(d) verification of completion of any continuing education that must be met by the licensee.

(3) Any licensee not renewed by November 15 is automatically cancelled and may not be reinstated."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 5, Ch. 142, L. 1993

"VIII INACTIVE LICENSES - REACTIVATION (1) Licensees who fail to provide evidence of meeting the required continuing education at the appropriate requirement period must place their license on inactive status by:

(a) paying the required fee;

(b) forwarding the license and pocket card to the board office for cancellation of active license status; and

(c) providing a written request that the license be placed on inactive status.

(2) Property management licensees who have placed their property management license on inactive status have the sole responsibility to keep the board informed as to any change of residency or mailing address during the period of time the licensees remain on inactive status.

(3) Inactive licensees must renew their license annually to maintain licensed status.

(4) For inactive property management licensees to again become active, they must:

(a) file a written change of address and pay the required fee;

(b) submit proof of obtaining 8 classroom or equivalent hours of continuing education for each two year period of inactive status or any combination of active and inactive status."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 37-51-311 and Sec. 4, Ch. 142, L. 1993

"IX CONTINUING PROPERTY MANAGEMENT EDUCATION (1) Each property management licensee is required to complete a minimum of 8 hours of board approved continuing property management education for every two (2) years of licensing.

(2) The required hours must be completed within the two-year period and no hours in excess will carry over to any other two-year period. Inactive licensees may obtain the full amount due just prior to reactivation.

(3) No course shall be repeated for credit unless the course content has been substantially changed or been

substantially updated and the provider has obtained approval from the board to offer it for repeat credit.

(4) Proof of successful completion must be submitted to the board with the licensee's renewal application at the conclusion of every two (2) year period, except that inactive licensees shall provide proof of completion at the time of reinstatement. No course completion certificates will be accepted by the board at any other time.

(5) The course provider must supply each licensee with a course completion certificate and student evaluation form approved by the board and must verify attendance of each licensee."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 5, Ch. 142, L. 1993

"X CONTINUING PROPERTY MANAGEMENT EDUCATION -- COURSE APPROVAL (1) Requests for approval of any change in subject matter, and renewal of approval, of a continuing property management education course must be made on forms approved by the board and submitted 45 days prior to the intended course, with payment of the required fees.

(2) Approval of a course and renewal of approval of a course shall be for two-year periods, but may be revoked for cause.

(3) Courses must consist of at least three hours of instruction and must be designed so that no more than 10 minutes per hour are allowed for breaks in instruction.

(4) Property management courses offered in other states and approved by those other states' real estate licensing agency for continuing education and which meet the property management topic requirements are recognized and approved."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 5, Ch. 142, L. 1993

"XI CONTINUING PROPERTY MANAGEMENT EDUCATION -- INSTRUCTOR APPROVAL (1) Request for approval, change, and renewal of approval of a continuing education instructor must be made on forms approved by the board and submitted 45 days prior to the intended instruction with payment of the required fee.

(2) Approval of an instructor and renewal of approval of an instructor shall be for a two-year period, but may be revoked for cause.

(3) Approved instructors must have:

(a) at least a bachelor's degree in a field traditionally associated with the subject matter of property management transactions and a property manager's license or a bachelor's degree in a field traditionally associated with the subject matter of property management transactions and a broker's license; or

(b) at least two years of post-secondary education in a field traditionally associated with the subject matter of property management transactions with a generally recognized professional or educational designation; or

(c) extensive instructional background in property management education and property manager's license or

extensive instructional background in property management education and be a broker; or

(d) experience in the area of instruction and have a designation as a real estate instructor by the real estate educators association; or

(e) five years of experience in the subject being taught.

(4) Insofar as the property management related topic of instruction is limited to their fields of expertise, persons such as attorneys, investigators, government officers or employees or mortgage loan officers, may be approved as instructors or may act as speakers under the supervision of approved instructors."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 5, Ch. 142, L. 1993

"XII TRUST ACCOUNT REQUIREMENTS (1) Each property manager will maintain a separate bank account which will be designated a trust account wherein all down-payments, earnest money deposits, rent payments, security deposits, or other trust funds received by the property manager on behalf of a principal, third-party or any other person shall be deposited. Such trust accounts may be maintained in interest bearing accounts with the interest payable to the property manager, principal, third-party, or any other person, as may be designated by agreement. Interest payable to the property manager must be identified by agreement as consideration for services performed. Offices or firms having more than one property manager may utilize a single property management trust account.

(2) Trust accounts must be maintained in a federally insured bank or another recognized depository in Montana.

(3) All funds belonging to others and accepted by the property manager while acting in his capacity as a property manager must be deposited in an account separate from money belonging to the property manager.

(a) The name of such separate account must be identified by the words "trust account."

(b) Client's funds must be retained in this bank account until the transaction involved is consummated or terminated, at which time the property manager must account for the full amount received.

(c) Each property manager must only deposit trust funds received on property management transactions in his trust account and shall not commingle his personal funds or other funds in the trust account with the exception that a property manager may deposit and keep a sum not to exceed $1,000 in said account from his personal funds, including the interest earned on the trust account if the trust account is maintained in an interest bearing account and the interest accrues to the property manager, which sum shall be specifically identified and deposited to cover bank service charges relating to the trust account.

(4) A property manager may maintain more than one trust account, but must notify the board of each and every account by name and number.

(5) All trust money received by the property manager must be deposited in the property management trust account within three business days of receipt of the trust funds unless otherwise provided in the lease agreement or rental agreement.

(6) Maintenance of the trust account will be the responsibility of the property manager. Property managers are responsible at all times for deposits accepted by them or their property management staff.

(7) No payments of personal indebtedness of the property manager shall be made from such trust account other than a withdrawal of earned commissions payable to such property manager or withdrawals made on behalf of the beneficiaries of such trust account.

(8) Money held in the trust account which is due and payable to the property manager must be withdrawn within 5 business days after such money becomes due and payable to the property manager except as exempted in (3)(c) of this section.

(9) A property manager must maintain in his office a completed record of all funds received on property management transactions, in the following manner:

(a) a bank deposit slip showing the date of deposit, amount, source of money, and where deposited;

(b) monthly bank statements are to be retained and kept on file for five years;

(c) trust account checks must be numbered and all voided checks retained. The checks must denote the property manager's business name, address, and must be designated as "trust account";

(d) a record book which shows the chronological sequence in which funds are received and disbursed;

(i) for funds received, the journal must include the date, the name of the party who is giving the money, the name of the principal, and the amount;

(ii) for disbursements, the checkbook journal must include the date, the payee, and the amount;

(iii) a running balance must be shown after each transaction.

(10) A ledger must be kept to show the receipts and the disbursements as they affect a single, particular transaction or property as between the landlord and tenant, etc. The ledger must include the names of both parties to a transaction, the dates and the amounts received. When disbursing funds, the date, payee and the amount must be shown. A running balance must be shown after each transaction.

(11) The trust account must be reconciled monthly except in the case where there has been no activity during that month.

(12) Every property manager shall keep permanent records of all funds and property of others received by them for not less than 5 years from the date of receipt of any such funds or property."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 37-51-202 and 37-51-203, MCA

"XIII FEE SCHEDULE (1) Except as otherwise provided by statute or rule, the following fees are required by the board for each of the licensing services provided to property management licensees and listed below. All fees are subject to change by the board, within the limitations provided in 37-51-311, MCA.

(2) No part of the fees paid in accordance with the provisions of this chapter is refundable. Fees are deemed earned by the board upon receipt.

(3) Examination fees:	
(a) for initial examination	$ 40.00
(b) for each subsequent or rescheduling of examination	40.00
(4) For each original license	50.00
(5) For each annual renewal	40.00
(6) For each change of place of business or affiliation	30.00
(7) For each duplicate license where the original was lost or destroyed	15.00
(8) For each duplicate pocket card where the original was lost or destroyed	15.00
(9) Reinstatement of a license suspended or revoked within a license period	50.00
(10) For placing an active license inactive	10.00
(11) For activating an inactive license	30.00
(12) For each original recovery account assessment	35.00
(13) Late renewal fee	100.00
(14) Continuing education course application	50.00
(15) Continuing education instructor application	25.00
(16) List of licensees	20.00
(17) Pre-licensing course	200.00"

Auth: Sec. 37-1-134, 37-51-202, 37-51-203, MCA; IMP, Sec. 37-1-134, 37-51-207, MCA

"XIV GROUNDS FOR DISCIPLINE OF PROPERTY MANAGEMENT LICENSEES - GENERAL PROVISIONS - UNPROFESSIONAL CONDUCT (1) In any transaction in which a property management licensee is involved as a licensee or as a party, has held himself or herself out as a licensee, or in which any party has reasonably relied on a licensee's status as a licensee, violation of any statute or rule administered by the board may be considered by the board in determining whether or not the licensee:

(a) has violated Sec. 7, Ch. 142, L. 1993 by "demonstrating his unworthiness or lack of honesty"; and/or

(b) has violated Sec. 7, Ch. 142, L. 1993 by offering or attempting to offer property for sales.

(2) If the board determines that a licensee has committed an act in such fashion that a statute or the rules administered by the board has been violated, such act shall be deemed an act against the interest of the public for which the

board may reprimand, suspend, or revoke the license held by the licensee or take any other action permitted by law.

(3) In addition to all other provisions contained in the statutes and rules administered by the board, particularly Sec. 7, Ch. 142, L. 1993, failure to comply with any of the following will constitute an act against the interest of the public:

(a) Licensees must maintain a level of knowledge customary for licensees of this state, including laws and rules administered by the board, and shall not violate laws and rules affecting any transaction in which he or she acts.

(b) Licensees shall not engage in activities that constitute the practice of law.

(c) Licensees shall recommend that legal counsel be obtained when the interests of any party require it.

(d) Licensees, prior to engaging in the services of any attorney, insurance agent, or other like person or like entity, on behalf of a principal, third party or other person, shall inform the person obligated to pay for the services and obtain consent from that person.

(e) Licensees, in engaging or recommending the services of an attorney, insurance company, or other like person or entity, on behalf of a principal third party, or other person, shall disclose any family relationship, financial relationship and/or financial interest that the licensee or property management agency with which the licensee is associated may have in that person or entity being engaged or recommended.

(f) Licensees must endeavor to ascertain all pertinent facts concerning every property in any transaction in which the licensee acts, so that the licensee may fulfill the obligation to avoid error, exaggeration, misrepresentation, or concealment of pertinent facts.

(g) Licensees must act to preserve and maintain that good repute, honesty, trustworthiness, and competency to transact business in a manner to safeguard the interests of the public as is required to obtain a license.

(h) Licensees may not falsify documents, place signatures on documents without authority, or commit any act of forgery, fraud, misrepresentation, deception, misappropriation, conversion, theft or any other like act.

(i) Licensees may not enter a transaction or agreement with the intent not to perform.

(j) Licensees may make reasonable efforts to perform all obligations arising from any agreement entered into.

(k) Licensees may not lend a property management license to an unlicensed person.

(l) Property managers may not act as a broker unless they hold that license separately.

(m) A licensee must not knowingly submit false information to the board.

(n) Licensees may not violate the landlord-tenant act; section 70-24-101, MCA.

(o) Licensees may not violate the state and federal human rights statutes.

(p) Licensees may not violate the Americans With Disabilities Act.

(4) The revocation or suspension or other disciplinary treatment of any other professional or occupational license or privilege held by the licensee in this state or another state, whether as an attorney, salesperson, broker, appraiser, or similar occupation or profession, shall be grounds for license discipline in this state, if the board, after appropriate notice and hearing, determines that the substantive grounds for that disciplinary treatment demonstrates the licensee's unworthiness or incompetency to act as a property manager."

Auth: Sec. 37-1-131, 37-51-202, 37-51-203, MCA; IMP, Sec. 7, Ch. 142, L. 1993

REASON: These proposed rules are being submitted to implement the licensure of property managers, pursuant to Chapter 142 of the Session Laws of 1993. The rules, as proposed, provide mechanisms for education, application, examination, and licensing of property manager candidates. In addition, the rules provide disciplinary guidelines.

4. Interested 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 Realty Regulation, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., June 24, 1993.

5. Robert P. Verdon, attorney, has been designated to preside over and conduct the hearing.

BOARD OF REALTY REGULATION
JACK MOORE, CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 17, 1993.

BEFORE THE WEIGHTS AND MEASURES BUREAU
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment and adoption of rules pertaining to fees	)))))))	NOTICE OF PUBLIC HEARING ON ON THE PROPOSED AMENDMENT OF 8.77.102 FEES FOR TESTING AND CERTIFICATION AND ADOPTION OF NEW RULE I LICENSE FEE SCHEDULE FOR WEIGHING AND MEASURING DEVICES

TO: All Interested Persons:

1. On June 16, 1993, at 9:00 a.m., a public hearing will be held in the Director's Conference Room of the Department of Natural Resources, Main Floor, 1520 East Sixth Avenue, Helena, Montana, to consider the proposed amendment and adoption of the above-stated rules.

2. The proposed amendment will read as follows: (new matter underlined, deleted matter interlined)

"8.77.102 FEES FOR TESTING AND CERTIFICATION

(1) Special inspection fees:

(a) units over 5,000 pounds of testing weights ~~$1.00~~ $2.50 a mile;

(b) all other units ~~$0.50~~ $1.25 a mile;

(c) additional time for testing by inspection ~~$30.00~~ $75.00 an hour.

(2) Where fees are not paid within thirty (30) days after the special inspection, the equipment will be sealed and removed from service by the ~~sealer~~ inspector of weights and measures, or his deputies, until such fees have been paid. The weights and measures bureau will coordinate the special inspections, whenever possible, with other inspection activities in an effort to keep charges as reasonable as possible."

Auth: Sec. 30-12-202, MCA; IMP, Sec. 30-12-202, MCA

3. The proposed new rule will read as follows:

"I LICENSE FEE SCHEDULE FOR WEIGHING AND MEASURING DEVICES (1) Measuring device fees will be as follows:

(a) each gasoline pump, diesel pump, or fuel oil pump measuring device per nozzle $14;

(b) each petroleum vehicle tank meter or bulk petroleum meter of 2 inches (5.00 centimeters) and under $50;

(c) each bulk petroleum meter over 2 inches (5.00 centimeters $60;

(d) each liquefied petroleum liquid meter $75;

(e) each vapor meter $10;

(f) each petroleum and liquified petroleum vehicle tank up to and including 2,000 gallons (7,570 liters) $60;

(g) each petroleum and liquified petroleum vehicle tank over 2,000 gallons (7,570 liters) $60 plus $12 for each additional 1,000 gallons (3,785 liters).

(2) Weighing device fees shall be as provided in section 30-12-203(3), MCA."

Auth: Sec. 82-15-102, MCA; IMP, Sec. 82-15-105, MCA

REASON: The proposed amendment to the fees for testing and certification of measuring and weighing devices is necessary to cover the increased costs of making the program self supporting rather than general funded. Since the program has only been generating a portion of what the actual costs are, the proposed amendment will make the fees commensurate with the actual costs of the program.

The new rule is being proposed to provide for measuring device inspection fees, which were deleted from the statutes during the 53rd Legislative Session. The Bureau is now a self supporting program, rather than a general fund program, and thus fees for measuring devices must be set commensurate with the budget for the program. Although the measuring device fees are set by the Department in administrative rule, the weighing device fees were set in statute and thus the clarification in the rule to inform persons where the fees can be found.

3. Interested 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 Weights and Measures Bureau, Room 50, Department of Natural Resources and Conservation building, 1520 East Sixth, Helena, Montana 59620, to be received no later than 5:00 p.m., June 24, 1993.

4. An attorney designated by the Department of Commerce will preside over and conduct the hearing.

WEIGHTS AND MEASURES BUREAU
PUBLIC SAFETY DIVISION
W. JAMES KEMBEL, ADMINISTRATOR

BY: Anne M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 17, 1993.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 11.12.101, 11.12.413, 11.12.416 and 11.12.417 pertaining to youth care facilities.	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT OF RULES 11.12.101, 11.12.413, 11.12.416 AND 11.12.417 PERTAINING TO YOUTH CARE FACILITIES

TO: All Interested Persons.

1. On June 16, 1993, at 1:30 p.m., a public hearing will be held in the auditorium of the Department of Social and Rehabilitation Services building, located at 111 Sanders, Helena, Montana, to consider the proposed amendment of Rules 11.12.101, 11.12.413, 11.12.416 and 11.12.417 pertaining to youth care facilities.

2. The rules as proposed to be amended read as follows:

11.12.101 YOUTH CARE FACILITY, DEFINITIONS Subsections (1)(a) and (1)(b) remain the same.

(c) "Youth care facility" (YCF) means a licensed facility in which substitute care is provided to youth ~~in need of care, youth in need of supervision, or delinquent youth~~ and includes youth foster homes, youth group homes, therapeutic youth group homes, and child care agencies.

Subsections (1)(d) through (2)(d) remain the same.

(3) The following definitions apply only to youth care facilities which are licensed as therapeutic youth group homes:

(a) "Therapeutic youth group home" is a youth care facility ~~under contract with the department and~~ licensed by and under contract with the department as a therapeutic youth group home, in which staff who are trained to provide services to emotionally disturbed youth in a therapeutic environment, perform assessments, develop and implement planned treatment interventions designed to address a youth's therapeutic needs in accordance with an individualized written treatment plan, and provide group, individual and family therapy. Providers of moderate, intermediate and intensive therapeutic youth group home services must directly employ or contract for services of clinicians, program managers, child care staff, relief staff, and administrative staff.

Subsections (3)(b) and (3)(c) remain the same.

(d) "Intermediate level" means the supervision and intensity of treatment required in a therapeutic youth group home to manage and treat children who present severe emotional and/or behavioral disorders as evidenced by meeting four or more of the medical necessity criteria set forth in ARM 11.12.417. Treatment, therapeutic interventions and supervision are tailored to the age and diagnosis of the children served. Therapeutic interventions are individualized and are provided

several times per day. Intermediate level care is provided on a campus with an on-grounds school where treatment is provided throughout the milieu. In addition to treatment, the children are provided with 24 hour awake staff supervision.

~~(d)~~(e) "Intensive level" means the supervision and intensity of treatment required in a therapeutic youth group home to manage and treat children who present severe emotional and/or behavioral disorders as evidenced by meeting five or more of the medical necessity criteria set forth in ARM 11.12.417. Treatment, therapeutic interventions and supervision are tailored to the age and diagnosis of the children served. Therapeutic group and individual interventions are provided several times per day. In addition, specialized behavior management techniques are incorporated into the treatment and supervision of children requiring intensive level services. The children are provided with 24 hour awake supervision.

~~(e)~~(f) "Lead clinical staff (LCS)" is an employee of, or under contract with, the moderate, intermediate or intensive level therapeutic youth group home provider who is responsible for the supervision and overall provision of treatment services to children in the group home(s). The LCS must be a clinical psychologist, master level social worker (MSW), licensed professional counselor (LPC), or have a masters degree in a human services field with a minimum of one year of clinical experience.

~~(f)~~(g) "Program manager" is an employee of the moderate, intermediate or intensive level therapeutic youth group home provider who trains and supervises child care staff, and provides treatment under the clinical supervision of the LCS. Program managers must have a bachelor's degree in a human services field, or the experience or experience and education, equivalent to a bachelor's degree. Human services experience equivalent to a bachelor's degree for a non-degree program manager is six years. Each year of post-secondary education in human services for a non-degree program manager equals one year of experience.

~~(g)~~(h) "Medical necessity statement" documents the moderate, intermediate or intensive level of therapeutic youth group home services ordered by the physician, clinical psychologist, master level social worker (MSW), or licensed professional counselor (LPC).

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.12.413 YOUTH GROUP HOME, STAFF Subsections (1) through (5) remain the same.

(6) Moderate level therapeutic youth group home providers must meet additional minimum staffing requirements to provide a therapeutic environment and treatment interventions identified in the child's individual treatment plan as follows:

(a) Child/staff ratio must be no more than 4:1 each day for a fifteen hour period beginning at, or between, 7:00 a.m. and 7:30 a.m., (or beginning at or between some other reasonable

morning half-hour which is approximately fifteen hours prior to the bed-time of the children), when children are in care.

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

(7) Intermediate level therapeutic youth group home providers must meet additional minimum staffing requirements to provide a therapeutic environment and treatment interventions identified in the child's individual treatment plan as follows:

(a) Child/staff ratio must be no more than 4:1 each day for a fifteen hour period beginning at, or between, 7:00 a.m. and 7:30 a.m., (or beginning at or between some other reasonable morning half-hour which is approximately fifteen hours prior to the bed-time of the children), when children are in care.

(b) Child/awake staff ratio must be no more than 8:1 each night for a nine hour period beginning no earlier than fifteen hours from the time day-time staffing of 4:1 is initiated.

(c) Each program manager shall be responsible for no more than four children.

(d) There must be adequate staff to allow the LCS, the program manager and/or professional support staff who provide services under the supervision of a masters or higher level clinician, to implement individualized treatment plans developed by the treatment team. Documentation of individual, group and family therapy must be completed for each session and be included in quarterly treatment summaries. Treatment plans shall include, but are not limited to:

(i) specific treatment plan objectives and interventions which are carried out in the treatment environment and documented by daily charting;

(ii) two age-appropriate individual therapy sessions per week;

(iii) two age-appropriate group therapy sessions per week; and

(iv) family therapy sessions when appropriate and medically necessary.

(e) Individualized treatment plans are monitored weekly by the treatment team which includes but is not limited to, the directors of clinical services, operational services, and educational services, and the consulting child psychiatrist.

(f) Each LCS shall be responsible for no more than eight children.

(g) Each intermediate level therapeutic youth group home shall either employ or contract for a .33 full time social worker for each eight children in care. The social worker shall meet the minimum qualifications of a bachelor's degree and two years of related experience. Under this subsection, .33 full time social worker means a social worker working a minimum of 13 hours, twenty minutes per week.

(h) Each intermediate level therapeutic youth group home shall either employ or contract for a .33 full time clinical director for each eight children in care. The clinical director shall be licensed by the Montana Board of Psychologists. Under this subsection, .33 full time clinical director means a clinical director working a minimum of 13 hours, twenty minutes per week.

(i) Each intermediate level therapeutic youth group home shall either employ or contract for a .33 full time director of operations for each eight children in care. The director of operations position is a master's level position. Under this subsection, .33 full time director of operations means a director of operations working a minimum of 13 hours, twenty minutes per week.

(j) Each intermediate level therapeutic youth group home shall either employ or contract for a .20 full time registered nurse for each eight children in care. The registered nurse shall be licensed by the Montana Board of Nursing. Under this subsection, .20 full time registered nurse means a registered nurse working a minimum of 8 hours per week.

(k) Each intermediate level therapeutic youth group home shall either employ or contract for a director of educational services. The director of educational services must possess a master's degree in education.

~~(7)~~(8) Intensive level therapeutic youth group home providers must meet additional minimum staffing requirements to provide a therapeutic environment and treatment interventions identified in the child's individual treatment plan as follows:

(a) Child/staff ratio must be no more than 2:1 each day for a fifteen hour period beginning at, or between, 7:00 a.m. and 7:30 a.m., (or beginning at or between some other reasonable morning half-hour which is approximately fifteen hours prior to the bed-time of the children), when children are in care.

Subsections (7)(b) through (7)(e) remain the same except they are re-numbered (8)(b) through (8)(e).

~~(8)~~(9) In addition to the 4 hours of orientation referenced in subsection (4) above, child care staff in a moderate, intermediate or intensive level therapeutic youth group home must receive 15 hours of initial training, and each year must complete 15 hours of additional in-service training in an area directly related to their duties. Initial and additional training must include the use of physical and non-physical methods of controlling children and adolescents to assure protection and safety of the client and staff.

~~(9)~~(10) These rules do not preclude a medicaid eligible youth from receiving individual therapy services in addition to moderate, intermediate or intensive level therapeutic youth group home services when there is compliance with medicaid requirements and reimbursement.

(11) Each therapeutic youth group home provider must assure, and provide appropriate documentation that:

(a) all children receiving treatment in the therapeutic youth group home receive a Well-Child screening on an annual basis; and

(b) all children receiving chemotherapy are seen by a licensed medical doctor at least quarterly or more often as required by the accepted protocol for the prescribed chemotherapy.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.12.416 YOUTH GROUP HOME, CHILDREN'S CASE RECORDS
Subsection (1) remains the same.
(2) The case record of each child receiving moderate, intermediate or intensive level therapeutic youth group home services must contain the following additional documentation:
(a) referral form/authorization for services;
(b) medical necessity statement;
(c) individual treatment plan, signed by the LCS, which documents the child's response to treatment (progress or lack of progress), and the staff's interaction and involvement with the client; and
(d) weekly clinical progress notes, reviewed and signed by the LCS, which summarizes the child's program participation and psychosocial/behavioral status and functioning.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.12.417 THERAPEUTIC YOUTH GROUP HOME, MEDICAL NECESSITY CRITERIA (1) Moderate, intermediate and intensive level therapeutic youth group home services must be ordered by a licensed physician, a licensed clinical psychologist, a licensed master level social worker (MSW), or a licensed professional counselor (LPC), and must be authorized by the department.
Subsection (1)(a) remains the same.
(b) Providers of intermediate level therapeutic youth group home services shall accept placement of only those children who meet at least four of the medical necessity criteria listed in subsection (2) below.
~~(b)~~(c) Providers of intensive level therapeutic youth group home services shall accept placement of only those children who meet at least five of the medical necessity criteria listed in subsection (2) below.
Subsection (2) remains the same.
(3) Medical Necessity Statement and Referral/Authorization forms must be completed and placed in the client record at the time of moderate, intermediate or intensive level therapeutic youth group home placement.
(4) The moderate, intermediate or intensive level therapeutic youth group home provider shall ensure appropriate involvement of a lead clinical staff (LCS) in each child's care. This involvement shall include an assessment, development of the treatment plan, and medical necessity determination with redetermination at a minimum of six month intervals. Continued placement at the moderate, intermediate or intensive ~~or moderate~~ level will be contingent upon medical necessity, achievement of treatment goals as outlined in the treatment plan, and other conditions as set out in the placement agreement required by ARM 11.12.415.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

3. In January of 1993, the Departments of Family Services

and Social and Rehabilitation Services implemented Medicaid funding for therapeutic youth group home services through companion rule-makings. The homes have contracted with DFS, and have been licensed by DFS. The companion rules established two levels of therapeutic youth group homes: moderate and intensive.

DFS, SRS, and DHES have been working with Intermountain Homes, a licensed child care agency in Helena, for the past two years on the proper place of Intermountain in the continuum of youth services. Intermountain has received a certificate of need for 32 beds for "residential treatment". Residential treatment is a level of service under the Medicaid program of "inpatient psychiatric services for individuals under age 21". Prior to, following, and during the certificate of need process the departments and Intermountain were uncertain whether that program should be adapted to meet the residential treatment facility requirements. Adapting the program would have resulted in an increase in the per diem rate paid to the facility. Neither DFS nor Intermountain wanted to change the program that dramatically, indeed, DFS had actively opposed the certificate of need for Intermountain as a residential treatment facility.

During the 1993 Legislative Session, efforts of the departments and Intermountain to arrive at a solution were intensified when the Legislature directed DFS to develop Medicaid availability for Intermountain. Through the process that followed agreement was reached that the best option was to expand the current therapeutic youth group home service by adding an "intermediate level" of treatment. The amendments proposed in this rule-making are reasonably necessary to meet Legislative objectives in regard to medicaid funding for services at Intermountain.

The intermediate level will cover those youth group home programs that are operated in a campus setting with sufficient staff to offer a variety of intensive treatment and educational services to children and youth who meet four or more of the medical necessity criteria for admission to the therapeutic youth group home program.

This rule-making also deletes language from ARM 11.12.101. ARM 11.12.101(1)(c) is changed to eliminate language implying that youth care facilities only serve youth adjudicated as youth in need of care, youth in need of supervision, and delinquent youth. ARM 11.12.101(3)(a) moves the phrase "under contract with the department" so that it follows "licensed by" [the department] instead of preceding "licensed by". The department intends to clarify that the home must be both licensed and under contract to operate as a therapeutic group home.

The new subsection (11) of ARM 11.12.413 is proposed to assure adequate health check-ups and adequate supervision of chemotherapy.

4. The proposed amendments will be effective for services

provided on or after July 1, 1993. Since intermediate level services currently are not covered by medicaid, retroactive coverage for services provided on or after July 1, 1993, will have no adverse effect upon providers or recipients.

5. Interested persons may submit their written and/or verbal data, views or arguments at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than June 26, 1993.

6. The Office of Legal Affairs, Department of Family Services, has been designated to preside over and conduct the hearing.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, May 17, 1993.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of Rule I, and the amendment of Rules 11.7.601, 11.7.602, 11.7.604, 11.7.608 and 11.7.609 pertaining to youth care facilities.	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION OF RULE I, AND AMENDMENT OF RULES 11.7.601, 11.7.602, 11.7.604, 11.7.608 and 11.7.609 PERTAINING TO YOUTH CARE FACILITIES

TO: All Interested Persons.

1. On June 18, 1993, at 1:30 p.m., a public hearing will be held in the second floor conference room of the Department of Family Services, 48 North Last Chance Gulch, Helena, Montana, to consider the adoption of Rule I, and the amendment of Rules 11.7.601, 11.7.602, 11.7.604, 11.7.608 and 11.7.609 pertaining to youth care facilities.

2. The rules as proposed to be adopted and amended read as follows:

RULE I FOSTER CARE SUPPORT SERVICES, DIAPER ALLOWANCE

(1) Any child who is placed in a licensed foster home is eligible for a diaper allowance if:

(a) the child is expected to be in foster care for more than 30 days;

(b) the department is making foster care payments for the child; and

(c) there is a need for diapers as documented by the placing worker.

(2) The amount of the diaper allowance is $40 per month per eligible child.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.7.601 FOSTER CARE SUPPORT SERVICES, PURPOSE (1) The purpose of this ~~rule~~ subchapter is to establish eligibility criteria for foster care support services. Payment for foster care support services may be made on behalf of foster children who require diapers, clothing, respite care, dietary aids, transportation, and other specific special services which are not available from other sources.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.7.602 FOSTER CARE SUPPORT SERVICES, DEFINITIONS For the purposes of this rule, the following definitions apply:

Subsection (1) remains the same.

(2) "Foster care support services" means a diaper allowance,

clothing allowance, respite care allowance, diet support allowance or other special need allowance paid on behalf of a foster child who has a documented need for such foster care support services.

(3) "Diaper allowance" means payments made on behalf of a foster child for diapers subject to the conditions and limitations set forth in [Rule I].

Subsections (3) through (6) remains the same except they are re-numbered (4) through (7).

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.7.604 FOSTER CARE SUPPORT SERVICES, CLOTHING ALLOWANCE Subsection (1) remains the same.

(2) The amount of the clothing allowance is determined by the child's wardrobe and the extent to which clothing is needed, but in no case may the amount exceed ~~$300~~$400 per child for the consecutive 12 month period beginning on the date that the department makes the initial clothing allowance payment. The maximum amount of the clothing allowance may be paid in increments as determined by the department.

Subsection (3) remains the same.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.7.608 FOSTER CARE SUPPORT SERVICES, SUPPLEMENTAL SERVICES ALLOWANCE Subsections (1) through (4) remain the same.

(5) All other supplemental services allowances shall be limited to the lesser of:

(a) actual costs; or

(b) ~~$50~~$87.50 per month per child.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

11.7.609 FOSTER CARE SUPPORT SERVICES, RESPITE CARE ALLOWANCE Subsection (1) remains the same.

(2) The amount of the respite care payment(s) shall not exceed:

(a) ~~$24~~ per hour per child for up to eight continuous hours;

(b) ~~$16~~32 per child for more than 8 hours and up to 24 hours.

Subsection (3) remains the same.

AUTH: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.
IMP: Sec. 41-3-1103, 41-3-1142 and 52-2-111, MCA.

3. The proposed amendments implement increased amounts for foster care support services which were appropriated by the 1993 Legislature through passage of House Bill 2.

4. Interested persons may submit their data, views or

arguments at the hearing. Written data, views or arguments may also be submitted to the Office of Legal Affairs, Department of Family Services, 48 North Last Chance Gulch, P.O. Box 8005, Helena, Montana 59604, no later than June 26, 1993.

5. The Office of Legal Affairs, Department of Family Services, has been designated to preside over and conduct the hearing.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, May 17, 1993.

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

In the matter of the proposed amendment of rules related to chiropractic services and fees in workers' compensation matters	) NOTICE OF PUBLIC HEARING ON) PROPOSED AMENDMENT OF) 24.29.1531, USE OF FEE) SCHEDULES; 24.29.1561) PHYSICIAN FEES - MEDICINE;) AND 24.29.1571, PHYSICIAN) FEES - CHIROPRACTIC) EVALUATIONS

TO ALL INTERESTED PERSONS:

1. On June 18, 1993, at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services building (north entrance), 111 North Sanders, Helena, Montana, to consider the amendment of rules related to chiropractic services and fees in workers' compensation matters.

The Department of Labor and Industry will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the Department by not later than 5:00 p.m. June 14, 1993, to advise us of the nature of the accommodation that you need. Please contact the Employment Relations Division, attn: Ms. Jeanne Johns, P.O. Box 8011, Helena, MT 59604-8011; telephone (406) 444-6526; TDD (406) 444-5549; fax (406) 444-4140.

2. The hearing will be held in response to a petition submitted by the State Compensation Mutual Insurance Fund ("State Fund"), Helena, Montana. The State Fund requests that the Department amend its rules concerning chiropractic services and fees in workers' compensation matters.

3. The rules as proposed by the State Fund to be amended provide as follows: (new matter underlined, deleted matter interlined)

Rule 24.29.1531 USE OF FEE SCHEDULES (1) Remains the same.

(a) The relative value scales given in the most current edition of the Relative Values for Physicians (RVP), published by Systemetrics/McGraw-Hill to be used by doctors of medicine, doctors of podiatry, and doctors of osteopathy, ~~and doctors of chiropractic,~~ for the following specialty areas:

(i) Remains the same.
(ii) Remains the same.
(iii) Remains the same.
(iv) pathology; and
(v) medicine~~; and~~ .
~~(vi) chiropractic, except chiropractic evaluations.~~

(b) Remains the same.
(i) Remains the same.
(ii) Remains the same.
(iii) Remains the same.
(iv) Remains the same.
(v) chiropractic~~;~~ ~~evaluations only.~~
(c) Remains the same.
(d) Remains the same.
(2) through (11) remain the same.
AUTH: Sec. 39-71-203, MCA IMP: Sec. 39-71-704, MCA

Rule 24.29.1561 PHYSICIAN FEES -- MEDICINE (1) and (2) remain the same.
(3) Remains the same.
(a) Effective April 1, 1993, the conversion factor for each medical specialty area services performed by a doctor of medicine, doctor of osteopathy, and doctor of podiatry~~, and doctor of chiropractic~~ are as follows:

	Specialty Area	Procedure Codes	Conversion Factor
(i)	Medicine	90000 - 99999	$ 3.77
(ii)	Surgery	10000 - 69999	80.55
(iii)	Radiology (Professional or Total Component)	70000 - 79999	15.59
(iv)	Pathology	80000 - 89999	13.50

AUTH: Sec. 39-71-203, MCA IMP: Sec. 39-71-704, MCA

Rule 24.29.1571 ~~PHYSICIAN FEES~~ -- CHIROPRACTIC ~~EVALUATIONS~~ FEES (1) Except as otherwise provided by this rule, fees for medical specialty area services rendered by chiropractors are payable only for the procedure codes listed below, according to the unit values listed. None of the procedure codes, descriptions, or unit values in relative values for physicians apply to chiropractic. ~~according to the values listed in Relative Values for Physicians.~~
(2) Remains the same.
(3) Remains the same.
(a) ~~Effective April 1, 1993, the conversion factor for evaluation services, procedure codes C9201 through C9299, and other medical services performed by a doctor of chiropractic within the scope of the practice is $3.77.~~ The conversion factor for office visits is $5.87, and for diagnostic x-rays is $11.07.
~~(4) The unit value for each procedure listed in subsection (6) includes the value for the associated office visit.~~
~~(5) Where the fee for a procedure depends on the time spent by the provider, the time spent on the completion of reports is already included within the procedure code unless otherwise noted.~~
~~(6)~~ (4) The following special procedure codes, with the associated description and unit values, are recognized for chiropractic ~~evaluations~~ services.

	Procedure Code	Description	Unit Value
(a)	99201	Brief Consultation and Examination New Patient. This examination includes a brief history of the problem only, as well as inspection of the problem area, not including Orthopedic and/or neurological testing. Very straightforward Chiropractic decision making involved. This is usually a self limited or minor problem.	5.2
(b)	99202	Limited Consultation and Examination New Patient. This includes an expanded, problem focused history with documentation of chief complaints, and nature of injury. An expanded, problem focused examination would include documentation of at least two of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration. Presenting problems are usually of low to moderate severity involving straightforward Chiropractic decision making.	9.6
(c)	99203	Intermediate Consultation and Examination, New Patient. This includes documentation of a detailed history of chief complaints, nature of injury and past history including pre existing conditions. A detailed examination should include documentation of at least three of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory test, reflexes, mensuration. Presenting problems are usually of moderate severity involving Chiropractic decision making of low complexity.	11.2
(d)	99204	Extended Consultation and Examin-	16.0

		ation,---New---Patient.------This includes---documentation---of---a comprehensive--history--of--chief complaints,-nature-of-injury-and past--history,---including---pre-existing----conditions.-----A comprehensive-examination-should include-documentation-of-at-least four----of----the----following: Inspection,--range---of--motion, palpatory--findings,--appropriate orthopedic---tests,----muscle strength,----sensory----tests, reflexes,----mensuration. Presenting--problems-are--usually of--moderate--to--high--severity involving--chiropractic--decision making---of---moderate---severity. Procedure-includes-preparation-of short-narrative-and-findings.	
(e)	99205	Comprehensive-Consultation-and Examination,--New--Patient.---This includes---documentation---of---a comprehensive--history--of--chief complaints,-nature-of-injury-and past--history,---including---pre-existing----conditions.--------A comprehensive-examination-should include-documentation-of-at-least five----of----the----following: Inspection,--range---of--motion, palpatory--findings,--appropriate orthopedic---tests,----muscle strength,----sensory----tests, reflexes,----mensuration. Presenting-problems-are-usually of--moderate--to--high--severity involving--chiropractic--decision making---of---high---complexity. Procedure-includes-preparation-of short-narrative-and-findings.	20.0
(f)	99211	Brief-Office-Visit-for-Evaluation and----Management,----Established Patient.--May--not--require--the presence----of----a----physician. Presenting-problems-are-usually minimal-and-typically-5-minutes or-less-are-spent-performing-or supervising-these-services.	2.0
(g)	99212	Limited-Office-Visit-For-Eval-	4.0

uation and Management, Established Patient. This includes at least two of the following three key components:

(i) A problem focused history;

(ii) A problem focused examination, including documentation of at least two of the following: inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration;

(iii) Straightforward chiropractic decision making. Usually, presenting problems are self limited or minor;

(h)	99213	Intermediate Office Visit For Evaluation and Management, Established Patient. This includes at least two of the following three key components: (i) An expanded, problem focused history; (ii) An expanded, problem focused examination, including documentation of at least three of the following: inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration; (iii) Chiropractic decision making of low complexity. Usually presenting problems are of low to moderate severity;	7.8
(i)	99214	Extended Office Visit For Evaluation and Management, Established Patient. This includes at least two of the following three key components: (i) A detailed history; (ii) A detailed examination including documentation of at least four of the following: inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration; (iii) Chiropractic decision making of moderate complexity.	11.6

~~Usually presenting problems are of moderate to high severity. Procedure includes preparation of short narrative and findings.~~

~~(j) 99215 Comprehensive Office Visit For Evaluation and Management, Established Patient. This includes at least two of the following three key components:~~

~~(i) A comprehensive history.~~

~~(ii) A comprehensive examination, including documentation of at least five of the following: Inspection, range of motion, palpatory findings, appropriate orthopedic tests, muscle strength, sensory tests, reflexes, mensuration.~~

~~(iii) Chiropractic decision making of high complexity. Usually, presenting complaints are of moderate to high severity. Procedure includes preparation of short narrative and findings.~~ ~~17.6~~

(a)	Procedure Code	Description - Office Visits	Unit Value
	90000	Initial Visit - Examination, history and treatment	5.9
	90010	Initial Visit - Examination, history and treatment	7.6
	90040	Subsequent Visits - exam and treatment; adjustment	3.5
	97000	Office Visit with one of the following modalities to one area: a) Hot or cold packs. b) Traction, mechanical. c) Electrical stimulation. d) Diathermy.	4.0
	97050	Office visit with two or more modalities to same area	4.8

(b)	Procedure Code	Description - Diagnostic X-rays	Unit Value
		Spine and Pelvis	
	72040	Cervical A-P and lateral	3.8
	72050	Complete - 4 view	6.0
	72052	Including flexion and extension views	

	(prior authorization required)	7.7
72070	Thoracic - A-P and lateral	4.4
72100	Lumbar, limited	4.4
72110	Lumbosacral, complete - 4 views	7.4
72114	Including bending views (prior authorization required)	9.3
72220	Sacrum and coccyx	4.1
	Upper extremities	
73000	Clavicle	3.1
73010	Scapula	3.8
73020	Shoulder, limited	2.7
73060	Humerus, including one joint	3.1
73070	Elbow	2.8
73100	Wrist, limited	2.5
73120	Hand, limited	2.5
	Lower Extremities	
73500	Hip, unilateral, limited	3.1
73550	Femur (thigh), including one joint	3.8
73560	Knee, limited	2.7
73590	Tibia and fibula (leg), including one joint	3.1

(c) Reports are required. X-rays are subject to call and review.

AUTH: Sec. 39-71-203, MCA IMP: Sec. 39-71-704, MCA

REASON: The State Fund asserts a separate chiropractic fee schedule is necessary which is not based on Relative Values for Physicians, published by Systemetrics/McGraw-Hill for the following reasons:

1) Under the current fee schedule, charges for chiropractic services exceed the increase in the State's average weekly wage as required by law.
2) The statistical methodology for determining fees payable pursuant to 24.29.1561 and 24.29.1571 is invalid in that it did not include the majority of chiropractic usage data.
3) The conversion factor promulgated by the Department of Labor is invalid, and if the correct usage data was utilized, would cause substantial decreases in fees to physicians while given chiropractors substantial increases in fees.
4) The lack of a separate fee schedule for chiropractors is inconsistent with the type of fee schedule historically used by the Department of Labor and inconsistent with the way other third party payors pay for chiropractic services.

4. The Department of Labor and Industry proposes to amend the rules as follows: (new matter underlined, deleted matter interlined)

Rule 24.29.1531 USE OF FEE SCHEDULES (1) Remains the same.

(a) The relative value scales given in the most current edition of the Relative Values for Physicians (RVP), published by Systemetrics/McGraw-Hill to be used by doctors of medicine, doctors of podiatry, and doctors of osteopathy, ~~and doctors of chiropractic,~~ for the following specialty areas:

(i) Remains the same.
(ii) Remains the same.
(iii) Remains the same.
(iv) pathology; and
(v) medicine, ~~; and~~
~~(vi) chiropractic, except chiropractic evaluations.~~
(b) Remains the same.
(i) Remains the same.
(ii) Remains the same.
(iii) Remains the same.
(iv) Remains the same.
(v) chiropractic ~~, evaluations only~~.
(c) Remains the same.
(d) Remains the same.
(2) through (11) remain the same.

AUTH: Sec. 39-71-203, MCA IMP: Sec. 39-71-704, MCA

Rule 24.29.1561 PHYSICIAN FEES -- MEDICINE (1) and (2) Remain the same.

(3) Remains the same.

(a) Effective April 1, 1993, the conversion factor for each medical specialty area services performed by a doctor of medicine, doctor of osteopathy, or doctor of podiatry, ~~and doctor of chiropractic~~ are as follows:

	Specialty Area	Procedure Codes	Conversion Factor
(i)	Medicine	90000 - 99999	$ 3.77
(ii)	Surgery	10000 - 69999	80.55
(iii)	Radiology (Professional or Total Component)	70000 - 79999	15.59
(iv)	Pathology	80000 - 89999	13.50

AUTH: Sec. 39-71-203, MCA IMP: Sec. 39-71-704, MCA

Rule 24.29.1571 ~~PHYSICIAN FEES~~ -- CHIROPRACTIC ~~EVALUATIONS~~ FEES (1) Except as otherwise provided by this rule, fees for medical specialty area services rendered by chiropractors are payable only for the procedure codes listed below, according to the unit values listed. None of the procedure codes, descriptions, or unit values ~~according to the values listed~~ in Relative Values for Physicians apply to chiropractic services.

(2) Remains the same.

(3) Remains the same.

(a) Effective ~~April~~ August 1, 1993, the conversion factor for ~~evaluation services, procedure codes C9201 through C9299, and other medical~~ services, other than diagnostic x-rays, performed by a doctor of chiropractic within the scope of the practice is $3.77.

(b) Effective August 1, 1993, the conversion factor for diagnostic x-rays is $15.59.

(4) ~~The unit value for each procedure listed in subsection (6) includes the value for the associated office visit.~~

~~(5) Where the fee for a procedure depends on the time spent by the provider, the time spent on the completion of reports is already included within the procedure code unless otherwise noted.~~

(6) The following special procedure codes, with the associated description and unit values, are recognized for chiropractic ~~evaluations~~ services:

	Procedure Code	Description	Unit Value
(a) through (j) remain the same.			
(k)	C9251	Manipulation only, single area of spine (includes C9211 office visit).	5.5
	C9252	Manipulation only, two or more areas of spine (includes C9211).	8.2
	C9253	Manipulation only, single area of when billed with an office visit, C9201 - C9215.	2.7
(l)	C9261	One of the following modalities, w/o manipulation (includes a C9211 office visit): (i) hot or cold packs, (ii) traction, mechanical, (iii) electrical stimulation, (iv) vasopneumatic devices, (v) paraffin bath, (vi) microwave, (vii) whirlpool, (viii) diathermy, (ix) infrared, (x) ultraviolet, (xi) other.	3.8
	C9262	Two or more modalities, w/o manipulation (includes C9211).	4.8
	C9263	One modality, w/o manipulation, when billed with an office visit, C9201 - C9215.	1.0
	C9264	Two or more modalities, w/o manipulation, when billed with an office visit, C9201 - C9215.	2.0
(m)	C9271	Manipulation, single area, with two or more modalities (consists of C9211, C9253 and C9264).	7.5

	C9272	Manipulation, two or more areas, w/ two or more modalities (consists of C9211, C9253 and C9264).	10.2
	C9273	Manipulation, one or more areas, w/ two or more modalities, when billed with office visit C9201 - C9215.	4.7
(n)	C9399	Special reports, service not listed, (includes impairment ratings).	BR

(5) Diagnostic x-rays are to be billed using the procedure codes and unit values listed in Relative Values for Physicians.
AUTH: Sec. 39-71-203, MCA IMP: Sec. 39-71-704, MCA

REASON: The Department is undertaking rulemaking in response to the petition filed by the State Fund. The Department believes that its proposed amendments address the issues and arguments raised by the State Fund in its petition, in a manner that is more consistent with the new medical service rules the Department just recently adopted and that became effective April 1, 1993.

The use of a separate chiropractic fee schedule is inconsistent with the goal of making health care billing procedures uniform, regardless of the provider and payor. Unique coding systems increase the cost to providers and payors by requiring special computer software for automated billing or costly manual billing. However, the Department recognizes that billing systems developed for medical doctors (the RVP) may not be appropriate for certain procedures performed by non-MDs. The Department has made the fewest possible changes to the current rules in the hope that providers and insurers would have minimal costs associated with modifying automated billing systems.

The amendments proposed by the Department allow providers to bill only for the services actually provided. The Department assumes that routine visits for established patients will only need a "brief" level of office visit services in addition to any treatment that is necessary. The proposed amendments provide a way for providers to perform manipulations only, without adding any modalities, if that is what is required for the condition being treated.

The amendments are structured so to provide the same fee whether services are "bundled" or "unbundled". For example, a routine chiropractic visit by an established patient who receives a spinal manipulation and two modalities can be billed in either of two ways:

(1) "bundled", as C9271 (7.5 units), OR
(2) "unbundled", as C9211 (2.8 units), plus C9252 (2.7 units), plus C9263 (2.0 units), for a total of 7.5 units.

The current rules allow chiropractors to separately charge for each physical medicine service provided. These amendments restore the concept of "combination codes" to the system, which take into account the practice of multiple services being

furnished during routine visits as part of a course of treatment. The use of "combination codes" is consistent with the historical application of fee schedule rules that have been applied to chiropractors in the workers' compensation setting in Montana. While other payors (such as private non-workers' compensation health insurers) may place limits on chiropractic rates and utilization by virtue of the insurance contract, the Department is obligated to follow the statutory requirement that reasonable medical services be furnished "without limitation as to time or dollar amount" [§ 39-71-704 (1)(a), MCA]. The Department, however, has the duty to establish a fee schedule [§ 39-71-704 (2), MCA]. (Addressing State Fund argument number four.)

These amendments also address the other concerns the State Fund has presented. The fees (conversion factor and the unit values) for chiropractic services have been compared to the fees charged under the pre-April 1, 1993, rules, and they more closely approximate the increase in the state's average weekly wage. The Department does not believe that 39-71-704 (4), MCA (1991) requires that fees for each specialty area is necessarily limited to the increase in the state's average weekly wage, so long as the overall medical costs are designed to be within that limit. (State Fund argument number one.)

Chiropractic data has been used in calculating the conversion factors for chiropractic services. The conversion factor for diagnostic x-rays was established using data from both chiropractors and medical doctors. The conversion factor for medical doctors, as found in ARM 24.29.1561, is not being amended. (State Fund arguments number two and three.)

5. The Department proposes to make these amendments effective August 1, 1993.

6. The State Fund identified the following persons as being known to have a possible interest in this proposal: chiropractors, physicians [medical doctors], and workers' compensation insurers. The Department believes that the following persons also have a possible interest in this proposal: members of the Montana legislature, self-insured employers, the professional licensing boards for chiropractors and medical doctors, and those persons who have previously requested notice of rulemaking activity concerning workers' compensation matters.

7. The Hearing Unit of the Legal Services Division of the Department has been designated to preside over and conduct the hearing.

8. Interested 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:

Dennis Zeiler, Bureau Chief
Standards Bureau
Employment Relations Division
Department of Labor and Industry
P.O. Box 8011
Helena, Montana 59604-8011

and must be received by no later than 5:00 p.m., June 25, 1993.

David A. Scott
Rule Reviewer

Laurie Ekanger, Commissioner
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: May 17, 1993.

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

In the matter of the proposed adoption of a new rule to reject, modify or condition permit applications in the Sharrott Creek Basin	)))))	NOTICE OF PUBLIC HEARING

TO: All Interested Persons.

1. On June 29, 1993 at 7:00 PM a public hearing will be held in the meeting room of Western Federal Savings Bank of Montana, 2601 Garfield, in Missoula, Montana, to consider the adoption of new rule I.

2. The proposed new rule provides as follows:

"RULE I. SHARROTT CREEK BASIN CLOSURE (1) Sharrott Creek Basin means the Sharrott Creek drainage area, a tributary of McCalla Creek located in the Bitterroot River hydrologic basin, 76H, in Ravalli County, Montana. The Sharrott Creek Basin designated as the closure area is all that drainage and head waters originating in the Bitterroot Mountains, Township 9 North, Range 21 West, MPM, and flowing easterly through Sections 19, 20, 28 & 29, Township 9 North, Range 20 West, MPM to its confluence with McCalla Creek at a point in Section 28, Township 9 North, Range 20 West, MPM Ravalli County, Montana. The entire Sharrott Creek drainage, from its headwaters to its confluence with McCalla Creek, including all tributaries is contained in the closure area, as outlined on file map labeled "1-B".

(2) The department shall reject all surface water applications to appropriate water within the Sharrott Creek Basin for any diversions, including infiltration galleries, for any consumptive uses of water during the period from January 1 through December 31.

(3) Applications for nonconsumptive uses during the closure period shall be received and processed. Any permit if issued shall be modified or conditioned to provide that there will be no decrease in the source of supply, no disruption in the stream conditions, and no adverse effect to prior appropriators within the reach of stream between the point of diversion and the point of return. The applicant for a nonconsumptive use shall provide sufficient factual information upon which the department can determine the applicants ability to meet the conditions imposed by this rule.

(4) Applications for groundwater shall be accepted, however the applicant shall provide sufficient factual information upon which the department can determine whether or not the source of the groundwater is part of or substantially or directly connected to surface water. If it is found that the proposed diversion of groundwater would cause a calculable reduction in the surface water flow during the closure period

the application shall be rejected. A calculable reduction means a theoretical reduction based on credible information as opposed to a measured reduction. If the applicant fails to submit sufficient factual information as required, the application shall be considered defective and shall be processed pursuant to 85-2-302, MCA.

(5) Emergency appropriations of water as defined in ARM 36.12.101(3) and 36.12.105 shall be exempt from these rules.

(6)This rule applies only to applications received by the department after the date of adoption of this rule.

(7) The department may, if it determines changed circumstances justify it, reopen the basin to additional appropriations and amend this rule accordingly after public notice and hearing."

AUTH: 85-2-112 and 85-2-319, MCA; IMP: 85-2-319, MCA

3. The rational for Rule I is that unappropriated water is not available in the Sharrott Creek basin for new consumptive appropriations of water throughout the year. On April 10, 1992 a petition was filed pursuant to 85-2-319, MCA with the Department of Natural Resources and Conservation. The petition requested the basin be closed year-round to all new appropriations of water. The petitioners claim Sharrott Creek does not have enough water in it to provide full usage by the existing decreed water right holders. They claim that decreed appropriations have been adversely affected for many years because of limited water supply in Sharrott Creek to support the existing water rights. In response to the petition the Department conducted a water availability analysis of the basin. As a result of the study the Department is proposing to reject new surface water permit applications for consumptive uses of water from January 1 to December 31. The intent of this rule is to preserve existing stream flows for senior appropriators. This rule sets out the class of applications affected, the type of appropriation that is exempt and allows the reopening of the basin through rule amendment notice and hearing.

4. Interested 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 Teresa McLaughlin, Department of Natural Resources and Conservation, 1520 E. 6th Avenue, Helena, MT, 59620 no later than July 1, 1993.

5. Vivian Lighthizer has been designated to preside at and conduct the hearing.

Mark Simonich, Director

BY: _____

Donald MacIntyre, Rule Reviewer

Certified to the Secretary of State May 17, 1993.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of [Rule I] pertaining to specified low income medicare beneficiaries	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF [RULE I] PERTAINING TO SPECIFIED LOW INCOME MEDICARE BENEFICIARIES

TO: All Interested Persons

1. On June 16, 1993, at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed adoption of [Rule I] pertaining to specified low income medicare beneficiaries.

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

[RULE I] SPECIFIED LOW INCOME MEDICARE BENEFICIARIES, APPLICATION AND ELIGIBILITY FOR MEDICAID (1) A person is a specified low income medicare beneficiary eligible for medicaid as provided in subsection (7) of this rule if the person:

(a) is entitled to medicare Part A benefits as provided in 42 USC 1395c et seq.;

(b) meets the nonfinancial criteria in subsection (3) of this rule;

(c) has countable resources not in excess of two times the resource limitation applicable to the federal supplemental security income (SSI) resource limitation at 42 USC 1382a; and

(d) has countable income as determined in accordance with this section;

(i) countable income may not be less than 100% of the federal poverty income standard nor more than:

(A) 110% of the federal poverty income standard for calendar year 1993; and

(B) 120% of the federal poverty income standard beginning January 1, 1994.

(2) When determining countable income, cost of living increases to the client's Title II social security benefits shall be excluded from December of each year through the month after the official federal poverty standards are published.

(3) The non-financial criteria for determining eligibility of a medicaid specified low income medicare beneficiary are that the person:

(a) is categorically eligible under the federal Social Security Act as being:

(i) age 65 or older;

(ii) blind; or

(iii) disabled;

(b) has a social security number;

(c) meets the citizenship or alienage requirements of ARM 46.12.3201; and

(d) meets the residency requirements of ARM 46.12.3202.

(4) A person in applying for and receiving medicaid as a specified low income medicare beneficiary is subject to the following provisions:

(a) ARM 46.12.3001 concerning application requirements;

(b) ARM 46.12.3002 concerning determinations of eligibility;

(c) ARM 46.12.3003 concerning redetermination of eligibility; and

(d) ARM 46.12.3204 concerning limitation on the financial responsibility of relatives.

(5) Countable income and resources will be determined using SSI criteria incorporated by reference in ARM 46.12.3603 (2).

(6) A person receiving medicaid as a specified low income medicare beneficiary must report within 10 days any changes in circumstances that may affect eligibility.

(7) Medicaid coverage for a person eligible for medicaid only as a specified low income beneficiary shall be limited to payment of medicare Part B premiums.

(8) A specified low income medicare beneficiary may be eligible for retroactive coverage for any or all of the three months immediately preceding the month of application, if the applicant met all of the financial and non-financial criteria set forth in subsections (1)(a) through (5) of this rule in that month.

AUTH: Sec. 53-2-201, 53-6-111 and 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-131 MCA

3. Section 4501 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) mandates limited medicaid coverage for aged, blind and disabled individuals whose income is between 100% and 110% of poverty in 1993 and between 100% and 120% of poverty beginning 1994. To qualify as a specified low income medicare beneficiary, the individual also must have resources which do not exceed two times the Supplemental Security Income (SSI) resource limit and meet residency and other eligibility requirements. Medicaid coverage for this group is limited to payment of medicare Part B premiums. The adoption of this rule is necessary to implement this new coverage group.

4. Interested parties 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 Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 24, 1993.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 17, 1993.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of rules 46.12.516 and 46.12.517 pertaining to medicaid coverage of intermediate level therapeutic youth group home treatment	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.516 AND 46.12.517 PERTAINING TO MEDICAID COVERAGE OF INTERMEDIATE LEVEL THERAPEUTIC YOUTH GROUP HOME TREATMENT

TO: All Interested Persons

1. On June 16, 1993, at 2:00 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of rules 46.12.516 and 46.12.517 pertaining to medicaid coverage of intermediate level therapeutic youth group home treatment.

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

46.12.516 KIDS COUNT/EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), ADDITIONAL SERVICES

Subsections (1) through (1)(e)(i) remain the same.

(ii) The therapeutic portion of intermediate level therapeutic youth group home treatment, as defined in DFS rules, is covered when provided by a therapeutic youth group home, licensed by DFS to provide intermediate level therapeutic youth group home services, to a child who meets DFS medical necessity criteria for placement at the intermediate level of treatment.

Subsections (1)(e)(ii) and (iii) remain the same in text but are renumbered (1)(e)(iii) and (iv).

Subsections (1)(f) and (g) remain the same.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

46.12.517 KIDS COUNT/EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT), REIMBURSEMENT

Subsections (1) through (3)(b) remain the same.

(c) Reimbursement for the therapeutic portion of intensive, intermediate and ~~or~~ moderate level therapeutic youth group home treatment services shall be as specified in a fee schedule set and maintained by the department as follows:

(i) An initial per diem fee shall be set by the department for each level of service in an amount equal to a percentage of the department of family services (DFS) per diem rate effective ~~January 1, 1993~~ for the same level of service, where such percentage is the same percentage of total DFS payments for

therapeutic youth group home treatment services which is reasonably allocable to the therapeutic component of the services~~, which excludes room, board, maintenance and other non-therapeutic services~~.

(A) For purposes of setting the initial fee for intensive and moderate level therapeutic youth group home treatment services, the DFS per diem rate shall be the DFS per diem rate effective January 1, 1993. For purposes of setting the initial fee for intermediate level services, the DFS per diem rate shall be the DFS per diem rate effective July 1, 1993.

(B) For purposes of setting fees under subsection (3)(c)(i), the therapeutic component of youth group home treatment services excludes room, board, maintenance and other non-therapeutic services.

Subsections (3)(c)(ii) through (6) remain the same.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113 MCA

3. The proposed amendments are necessary to implement medicaid coverage of the therapeutic portion of intermediate level youth group home treatment for medicaid eligible children under age 21. This coverage is being implemented under the "Kids Count"\Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program.

The medicaid program currently provides coverage of both intensive level and moderate level therapeutic youth group home treatment as a medicaid state plan service under 42 CFR 440.40, EPSDT services, with the goal of restoring the child to his or her best possible functional level. Under the proposed amendments, medicaid will reimburse for therapeutic youth group home treatment services at a level of intensity higher than the current "moderate" level but lower than the current "intensive" level. Addition of coverage of intermediate level services will improve recipient access to a continuum of care.

The proposed amendments are necessary to specify the requirements for coverage of intermediate level services and the methodology for determining reimbursement rates for such services. Only those group homes licensed by DFS to provide intermediate level therapeutic youth group home services will be eligible to receive medicaid reimbursement. Medicaid will reimburse only for the therapeutic treatment component of services provided and not for room and board costs. DFS will reimburse providers for room and board costs according to DFS rules and policies. Medicaid reimbursement rates for intermediate level services will be set using the same methodology used for intensive and moderate level services, except that rates will be based upon the DFS per diem in effect on the date medicaid coverage begins rather than on January 1, 1993.

4. The proposed amendments will be effective for services provided on or after July 1, 1993. Funding for intermediate

level therapeutic group home care was made available when the Governor signed House Bill No. 2 on May 10, 1993. Thus, an earlier rule notice was not possible to meet the July 1, 1993 effective date of the law. Since intermediate level services currently are not covered by medicaid, retroactive coverage for services provided on or after July 1, 1993 will have no adverse effect upon providers or recipients.

5. Interested parties 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 Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than June 24, 1993.

6. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 17, 1993.

BEFORE THE BOARD OF ATHLETICS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to athletics and the adoption of new rules implementing kickboxing	NOTICE OF AMENDMENT AND ADOPTION OF RULES PERTAINING TO THE ATHLETICS INDUSTRY

TO: All Interested Persons:

1. On March 25, 1993, the Board of Athletics published a notice of proposed amendment and adoption of rules pertaining to the athletics industry at page 363, 1993 Montana Administrative Register, issue number 6.

2. The Board has amended ARM 8.8.2801 through 8.8.2807; 8.8.2901 through 8.8.2905; 8.8.3101 through 8.8.3108; 8.8.3201 through 8.8.3204; 8.8.3301; 8.8.3401 through 8.8.3407; 8.8.3701; 8.8.3801 through 8.8.3806; and 8.8.4001 and has adopted new rules I (8.8.4101) through III (8.8.4103); V (8.8.4105); VII (8.8.4107) and VIII (8.8.4108) exactly as proposed. The Board has adopted new rules IV (8.8.4104) and VI (8.8.4106) as proposed but with the following changes:

"8.8.4104 FOULS (1) through (1)(i) will remain the same as proposed.

(2) All national, continental, intercontinental or world championship kickboxing athletic events shall ~~be required to compete under~~ comply with the regulations set forth by the karate international council of kickboxing.

~~(3) A contestant who executes a malicious foul may be subject to bearing the medical as well as related recovery and recuperation expenses of the opponent who is injured as a result of a malicious fouling technique.~~

(4) will remain the same as proposed but will be renumbered (3)."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

"8.8.4106 CONTESTANT'S EQUIPMENT (1) through (12) will remain the same as proposed.

(13) A standard karate uniform consisting of jacket, pants and belt, as traditionally worn in the sport of kickboxing or full-contact karate, ~~approved by the board~~ must be worn by all contestants upon entering the ring. No boxer trunks will be allowed.

(14) through (16) will remain the same as proposed."

Auth: Sec. 23-3-405, MCA; IMP, Sec. 23-3-405, MCA

3. The Board has thoroughly considered all comments and testimony received. Those comments and the Board's responses thereto are as follows:

COMMENT: Staff of the Administrative Code Committee commented as follows:

a. That the language "be required to" should be stricken from subsection (2) of new rule IV (Fouls), because under the

existing language, a board order would be required at each match.

b. That subsection (3) should be stricken from new rule IV because it did nothing more than restate issues of tort law.

c. That subsection (13) of new rule VI needs to clarify what kind of karate uniform and belt must be worn by contestants.

RESPONSE: The Board concurred and the amendments have been made as shown above.

4. No other comments or testimony were received.

BOARD OF ATHLETICS
ANDY VANDOLAH, CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 17, 1993.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.17.105 relating to Computation of Withholding	NOTICE OF THE AMENDMENT of ARM 42.17.105 relating to Computation of Withholding

TO: All Interested Persons:

1. On April 15, 1993, the Department published notice of the proposed amendment of ARM 42.17.105 relating to computation of withholding at page 525 of the 1993 Montana Administrative Register, issue no. 7.

2. No public comments were received regarding this rule.

3. The Department amends the rule as proposed.

CLEO ANDERSON
Rule Reviewer

MICK ROBINSON
Director of Revenue

Certified to Secretary of State May 17, 1993.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of rule 46.12.806 pertaining to durable medical equipment	)))	NOTICE OF THE AMENDMENT OF RULE 46.12.806 PERTAINING TO DURABLE MEDICAL EQUIPMENT

TO: All Interested Persons

1. On April 15, 1993, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rule 46.12.806 pertaining to durable medical equipment at page 531 of the 1993 Montana Administrative Register, issue number 7.

2. The Department has amended rule 46.12.806 as proposed.

3. This amendment will take effect July 1, 1993.

4. No written comments or testimony were received.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 17, 1993.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of rules 46.13.301, 46.14.301, 46.14.401 and 46.14.402 and the repeal of rules 46.14.201 through 46.14.205 pertaining to low income energy and weatherization assistance programs	)))))))	NOTICE OF THE AMENDMENT OF RULES 46.13.301, 46.14.301, 46.14.401 AND 46.14.402 AND THE REPEAL OF RULES 46.14.201 THROUGH 46.14.205 PERTAINING TO LOW INCOME ENERGY AND WEATHERIZATION ASSISTANCE PROGRAMS

TO: All Interested Persons

1. On April 15, 1993, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.13.301, 46.14.301, 46.14.401 and 46.14.402 and the repeal of rules 46.14.201 through 46.14.205 pertaining to low income energy and weatherization assistance programs at page 527 of the 1993 Montana Administrative Register, issue number 7.

2. The Department has amended rules 46.13.301, 46.14.301, 46.14.401 and 46.14.402 and repealed rules 46.14.201 through 46.13.205 as proposed.

3. No written comments or testimony were received.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 17, 1993.

VOLUME NO. 45 OPINION NO. 6

INSURANCE - Requirement of State Fund to provide employers' liability insurance;
WORKERS' COMPENSATION - Requirement of State Fund to provide employers' liability insurance;
MONTANA CODE ANNOTATED - Sections 39-71-101 to 39-71-2914, 39-71-105, 39-71-105(4), 39-71-407(1), 39-71-2101, 39-71-2201, 39-71-2301, 39-71-2311, 39-71-2313, 39-71-2316, 39-71-2316(1), 39-72-305(1);
OPINIONS OF THE ATTORNEY GENERAL - 44 Op. Att'y Gen. No. 35 (1992), 43 Op. Att'y Gen. No. 63 (1990).

HELD: The Montana Workers' Compensation Act does not require the State Compensation Mutual Insurance Fund to provide its policyholders with employers' liability insurance coverage.

May 12, 1993

Mr. Patrick J. Sweeney
President
State Compensation Mutual Insurance Fund
P.O. Box 4759
Helena, MT 59604-4759

Dear Mr. Sweeney:

You have requested my opinion on the following question:

> Is the State Compensation Mutual Insurance Fund required to provide employers' liability insurance in conjunction with providing workers' compensation and occupational disease liability insurance coverage to its policyholders?

I conclude that MCA § 39-71-2316(1) of the Workers' Compensation Act authorizes, but does not require, the State Compensation Mutual Insurance Fund [State Fund] to provide employers' liability insurance in conjunction with providing workers' compensation and occupational disease liability insurance coverage to its policyholders.

The Montana Workers' Compensation Act, MCA §§ 39-71-101 to -2914, permits employers to elect one of three methods for providing payments of benefits to injured employees: self-insurance, insurance purchased through a private carrier, or insurance purchased through the State Fund. See MCA §§ 39-71-2101, -2201, and -2311.

MCA § 39-71-2316(1) distinguishes between two types of employer coverage available through the State Fund: workers' compensation and occupational disease liability insurance, and employers' liability insurance. Workers' compensation and occupational disease liability insurance provides "wage supplement and medical benefits to a worker suffering from a work-related injury or disease." MCA § 39-71-105. This coverage protects the employee who receives an injury arising out of and in the course of employment. MCA §§ 39-71-407(1) and 39-72-305(1). In contrast, employers' liability insurance typically covers an employer's liability for bodily injury to an employee in those situations in which workers' compensation and occupational disease liability insurance does not apply. See 7B Appleman, Insurance Law and Practice § 4571 (1979). This coverage is generally included as part of the coverage for an employer when purchased through a private carrier.

The answer to your question hinges on the statutory construction of MCA § 39-71-2316, the only statute referring to employers' liability insurance, which provides:

> For the purposes of carrying out its functions, the state fund may: (1) insure any employer for workers' compensation and occupational disease liability as the coverage is required by the laws of this state and, in connection with the coverage, provide employers' liability insurance.

The goal in construing and applying a statute is to discern and effect legislative intent, through primary reliance on the plain meaning of the words used in the statute. MCA § 1-2-102; State ex rel. Roberts v. Public Service Comm'n, 242 Mont. 242, 246, 790 P.2d 489, 492 (1990); Thiel v. Taurus Drilling Ltd., 218 Mont. 201, 205, 710 P.2d 33, 35 (1985). Further, the Workers' Compensation Act is to be construed according to its terms and not liberally in favor of any party. MCA § 39-71-105(4).

Here, MCA § 39-71-2316(1) provides that "the state fund may ... provide employers' liability insurance" in connection with workers' compensation and occupational disease liability coverage. (Emphasis added.) The use of the word "may" in this section is not by itself determinative of the employers' liability insurance question, since "may" can be interpreted as either mandatory or permissive. State ex rel. Griffin v. Greene, 104 Mont. 460, 469, 67 P.2d 995, 999 (1937); 44 Op. Att'y Gen. No. 35 (1992); 43 Op. Att'y Gen. No. 63 (1990). Accordingly, the ambiguity created by use of the word "may" in MCA § 39-71-2316(1) is resolved by reviewing other provisions under Title 39, chapter 71, part 23, and determining from those provisions whether the Legislature intended to require the State Fund to provide employers' liability insurance. 44 Op. Att'y Gen. No. 35; 43 Op. Att'y Gen. No. 63.

MCA §§ 39-71-2311 and -2313 indicate that MCA § 39-71-2316(1) does not create an affirmative duty on the part of the State Fund to provide employers' liability insurance. MCA § 39-71-2311 sets forth the intent and purpose of the State Fund. It provides in pertinent part:

> It is the intent and purpose of the state fund to allow employers the option to insure their liability for workers' compensation and occupational disease coverage with a mutual insurance fund. The state fund is required to insure any employer in this state requesting coverage, and it may not refuse coverage for an employer unless an assigned risk plan established under 39-71-431 is in effect.

This statute specifically requires the State Fund "to insure any employer in this state requesting coverage, and it may not refuse coverage for an employer unless an assigned risk plan established under 39-71-431 is in effect." The statute prohibits the State Fund from refusing "coverage" absent an assigned risk plan. This statutory provision does not distinguish between workers' compensation and occupational disease coverage, and employers' liability insurance coverage. However, the first sentence of MCA § 39-71-2311 provides, "It is the intent and purpose of the State Fund to allow employers the option to insure their *liability for workers' compensation and occupational disease coverage* with a mutual insurance fund" (emphasis added). Thus, when taken in context, the statutory requirement of the State Fund "to insure any employer in this state requesting coverage" should be construed to require the State Fund to provide employers the option of procuring workers' compensation and occupational disease coverage, and not other types of coverage such as employers' liability insurance.

Additionally, MCA § 39-71-2313 declares that the State Fund was created "for the purpose of allowing an option for employers to insure their liability for workers' compensation and occupational disease coverage" under Montana's Workers' Compensation Act. MCA § 39-71-2313. The legislative intent of the State Fund is further indicated in the Statement of Intent attached to SB 428, the 1989 bill in which MCA § 39-71-2316 originated, which states: "The new State Fund would be bound to insure all employers who apply to it for workers' compensation coverage." Nothing in the language of the Workers' Compensation Act or its legislative history indicates a legislative intent to impose upon the State Fund an obligation to provide employers' liability insurance coverage.

I conclude, therefore, that MCA § 39-71-2316(1) authorizes the State Fund in its discretion to provide employers' liability insurance in connection with workers' compensation coverage and occupational disease coverage which it is required to provide employers under MCA § 39-71-2311. The word "may" under MCA

§ 39-71-2316(1) should be construed as discretionary: it is within the State Fund's discretion to provide employers' liability insurance.

THEREFORE, IT IS MY OPINION:

The Montana Workers' Compensation Act does not require the State Compensation Mutual Insurance Fund to provide its policyholders with employers' liability insurance coverage.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/dlh

BEFORE THE BOARD OF OUTFITTERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the petition for declaratory ruling on the applicability of section 37-47-101(5) to his activity	NOTICE OF PETITION FOR DECLARATORY RULING

1. The Petitioner's name and address is:

Larry Fish
2971 Deer Meadow Drive
Danville, California 94506

2. The Petitioner is the owner of a lodge in southwest Montana. The method of operation for the lodge is to furnish rooms and meals to paying guests. Guests are furnished maps of the area upon request. Those guests who hunt must provide their own transportation, seek their own hunting or fishing assistance and game or fish handling. No services are provided by lodge employees or owners for taking care of or processing any of the guests' game or fish.

3. During appropriate seasons hunters and fishermen are the main, if not the exclusive, users of the lodge. Petitioner expects from time to time to hunt and fish on federal, state, or private lands in the vicinity of the lodge with those guests who are his friends.

4. The statutes on which Petitioner requests a ruling are as follows:

Section 37-47-101(5), MCA:

"(5) "Outfitter" means any person, except a person providing services on real property that he owns for the primary pursuit of bona fide agricultural interests, who:
(a) engages in the business of outfitting for hunting or fishing parties, as the term is commonly understood;
(b) for consideration provides any saddle or pack animal or personal service for hunting or fishing parties or camping equipment, vehicles, or other conveyance, except boats, for any person to hunt, trap, capture, take, or kill any game and accompanies such a party or person on an expedition for any of these purposes;
(c) for consideration furnishes a boat or other floating craft and accompanies any person for the purpose of catching fish; or
(d) for consideration aids or assists any person in locating or pursuing any game animal."

Section 37-47-101(6), MCA:

"(6) "Professional guide" and "guide" mean a person:

(a) who is an employee of an outfitter and who furnishes only personal guiding services in assisting a person to hunt or take game animals or fish and who does not furnish any facilities, transportation, or equipment; or

(b) who has contracted independently with an outfitter and who furnishes personal guiding services and facilities, transportation, or equipment that he owns in assisting a person to hunt or take game birds or fish. A guide who provides independent contractor services to an outfitter may not provide facilities, equipment, or services for overnight use."

5. The question presented for declaratory ruling is whether Petitioner is prohibited by the provisions of section 37-47-301, MCA, from engaging in hunting with friends of his who may stay at his lodge.

6. The Petitioner contends his activity is not prohibited by the above statutes because he does not charge his friends for accompanying them hunting and/or fishing, but charges them for room and board at the lodge.

7. Petitioner requests a declaratory ruling that his activity is not prohibited by the above statutes.

8. Petitioner knows of no other party similarly affected.

BOARD OF OUTFITTERS
IRVING L. "MAX" CHASE

By: _____
ANDY J. POOLE, DEPUTY DIRECTOR
DEPARTMENT OF COMMERCE

_____
ROBERT P. VERDON, RULE REVIEWER

Certified to the Secretary of State, May 17, 1993.

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules, amendment or repeal of existing rules filed with the Secretary of State, except rules proposed by the Department of Revenue. Proposals of the Department of Revenue are reviewed by the Revenue Oversight Committee.

The Administrative Code Committee has 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. In addition, the Committee 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 or amend a rule.

The Committee welcomes comments from the public and invites members of the public to appear before it or to send it written statements in order to bring to the Committee's attention any difficulties with the existing or proposed rules. The address is Room 138, Montana State Capitol, Helena, Montana 59620.

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 Matter	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 which have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through March 31, 1993. This table includes those rules adopted during the period April 1, 1993 through June 30, 1993 and any proposed rule action that is pending during the past 6 month period. (A notice of adoption must be published within 6 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, 1993, this table and the table of contents of this issue of the MAR.

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BOARD APPOINTEES AND VACANCIES

House Bill 424, passed by the 1991 Legislature, directed that all appointing authorities of all appointive boards, commissions, committees and councils of state government take positive action to attain gender balance and proportional representation of minority residents to the greatest extent possible.

One directive of HB 424 was that the Secretary of State publish monthly in the *Montana Administrative Register* a list of appointees and upcoming or current vacancies on those boards and councils.

In this issue, appointments made in April, 1993, are published. Vacancies scheduled to appear from June 1, 1993, through August 31, 1993, are also listed, as are current recent vacancies due to resignations or other reasons.

Individuals interested in serving on a new board should refer to the bill that created the board for details about the number of members to be appointed and qualifications necessary.

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

IMPORTANT

Membership on boards and commissions changes constantly. The following lists are current as of May 4, 1993.

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

BOARD AND COUNCIL APPOINTEES: APRIL, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Appellate Defender Commission (Administration)			
Mr. Michael J. Reardon	Governor	Hood	4/16/1993
Victor			1/1/1996
Qualifications (if required): public defender			
Board of Hail Insurance (Agriculture)			
Mr. Lanny Christman	Governor	Zerbe	4/18/1993
Dutton			4/18/1996
Qualifications (if required): public member			
Mr. Leo Giacometto	Governor	Snortland	4/18/1993
Helena			1/1/1997
Qualifications (if required): Director of the Department of Agriculture			
Auditor Mark O'Keefe	Governor	Bennett	4/18/1993
Helena			1/1/1997
Qualifications (if required): State Auditor			
Board of Housing (Commerce)			
Mr. Paul Bankhead	Governor	Dahl	4/13/1993
Heron			1/1/1997
Qualifications (if required): public member			
Mr. Michael E. McKee	Governor	Mather	4/13/1993
Hamilton			1/1/1997
Qualifications (if required): public member			
Mr. William H. Oser	Governor	McCallum	4/13/1993
Billings			1/1/1997
Qualifications (if required): public member			

Appointee	Appointed by	Succeeds	Appointment/End Date
Board of Housing (Commerce) cont.			
Mr. Robert J. Savage Sidney Qualifications (if required): attorney	Governor	Gerbase	4/13/1993 1/1/1996
Board of Oil and Gas Conservation (Natural Resources and Conservation)			
Mr. David Ballard Billings Qualifications (if required): represents oil and gas industry	Governor	Schaenan	4/12/1993 1/1/1997
Ms. Judy Feland Shelby Qualifications (if required): represents public at large	Governor	Gage	4/12/1993 1/1/1997
Mr. George Galuska Billings Qualifications (if required): represents the oil and gas industry	Governor	Rhodes, Jr.	4/12/1993 1/1/1997
Capital Finance Advisory Council (Administration)			
Mr. Marvin Dye Helena Qualifications (if required): none specified	Director	not listed	4/26/1993 4/5/1994
Mr. David Lewis Helena Qualifications (if required): none specified	Director	not listed	4/26/1993 4/5/1994
Ms. Lois A. Menzies Helena Qualifications (if required): none specified	Director	not listed	4/26/1993 4/5/1994

BOARD AND COUNCIL APPOINTEES: APRIL, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Capital Finance Advisory Council (Administration) cont.			
Mr. Jon D. Noel Helena Qualifications (if required): none specified	Director	not listed	4/26/1993 4/5/1994
Mr. Robert J. Robinson Helena Qualifications (if required): none specified	Director	not listed	4/26/1993 4/5/1994
Mr. Mark Simonich Woodbridge Qualifications (if required): none specified	Director	not listed	4/26/1993 4/5/1994
Mr. Bob Thomas Stevensville Qualifications (if required): none specified	Director	not listed	4/26/1993 4/5/1994
Capitol Restoration Commission (Governor)			
Mr. Walter (Howdie) S. Murfitt Helena Qualifications (if required): public member	Governor	Amsberry	4/12/1993 12/3/1995
Commission for Human Rights (Labor and Industry)			
Ms. S. Jane Lopp Kalispell Qualifications (if required): public member	Governor	Regan	4/14/1993 1/1/1997
Ms. Gloria "Patt" Pattison Etchart Glasgow Qualifications (if required): public member	Governor	Arnott	4/14/1993 1/1/1997

BOARD AND COUNCIL APPOINTEES: APRIL, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Medical Care Advisory Council (Social and Rehabilitation Services)			
Mr. Fred Patten	Director	Kloeber	4/2/1993
Helena			0/0/0
Qualifications (if required): none specified			
Montana Health Facility Authority Board (Commerce)			
Ms. Joyce Asay	Governor	Bartos	4/13/1993
Forsyth			1/1/1997
Qualifications (if required): expert in hospital administration			
Montana Microbusiness Finance Program Advisory Council (Commerce)			
Mr. Richard C. King	Governor	Robson	4/1/1993
Chinook			8/21/1993
Qualifications (if required): expertise in revolving loan fund administration			
Public Employees' Retirement Board (Administration)			
Mr. Fred J. Flanders	Governor	Jamison	4/1/1993
Helena			4/1/1998
Qualifications (if required): member at large			
Mr. Troy W. McGee, Sr.	Governor	reappointed	4/1/1993
Helena			4/1/1998
Qualifications (if required): retired public employee			
Ms. Carol Lambert	Governor	McGreevey	4/1/1993
Hammond			4/1/1996
Qualifications (if required): member at large			

BOARD AND COUNCIL APPOINTEES: APRIL, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
State Employee Group Benefits Advisory Council (Administration)			
Mr. Mark Cress	Director	not listed	4/15/1993
Helena			9/1/1993
Qualifications (if required): none specified			
Ms. Debbie Gabse	Director	not listed	4/15/1993
Boulder			9/1/1993
Qualifications (if required): none specified			
Vocational Rehabilitation Divisions Advisory Council (Social and Rehabilitation Services)			
Mr. Jim Betty	Director	not listed	4/15/1993
Missoula			4/15/1995
Qualifications (if required): none specified			
Mr. Mark Bowlds	Director	not listed	4/15/1993
Helena			4/15/1995
Qualifications (if required): none specified			
Ms. Sally Cerny	Director	not listed	4/15/1993
Great Falls			4/15/1995
Qualifications (if required): none specified			
Mr. Ken Christensen	Director	not listed	4/15/1993
Helena			4/15/1995
Qualifications (if required): none specified			
Ms. Ladonna Fowler	Director	not listed	4/15/1993
Pablo			4/15/1995
Qualifications (if required): none specified			
Ms. Sandra Jarvie	Director	not listed	4/15/1993
Helena			4/15/1995
Qualifications (if required): none specified			

Appointee	Appointed by	Succeeds	Appointment/End Date
Vocational Rehabilitation Divisions Advisory Council (Social and Rehabilitation Services) cont.			
Mr. Robert LeMieux Great Falls Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995
Mr. Ralph Martin Bozeman Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995
Ms. Kelly Moorse Helena Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995
Ms. Gail Neal Billings Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995
Ms. Anita Nelson Missoula Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995
Mr. Pat Pope Helena Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995
Ms. Nancy Staigmiller Miles City Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995
Ms. Virginia Sutich Sand Coulee Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995

BOARD AND COUNCIL APPOINTEES: APRIL, 1993

Appointee	Appointed by	Succeeds	Appointment/End Date
Vocational Rehabilitation Divisions Advisory Council (Social and Rehabilitation Services) cont.			
Ms. Raelen Williard Helena Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995
Ms. Lynn Winslow Helena Qualifications (if required): none specified	Director	not listed	4/15/1993 4/15/1995

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Advisory Council on Food and Nutrition (Health)		
Mr. Bill Carey, Missoula	Governor	8/30/1993
Qualifications (if required): none specified		
Ms. Minkie Medora, Missoula	Governor	8/30/1993
Qualifications (if required): none specified		
Ms. Judy Morrill, Bozeman	Governor	8/30/1993
Qualifications (if required): none specified		
Ms. Freida Hicks, Helena	Governor	8/30/1993
Qualifications (if required): represents Montana Food Stamp Program		
Ms. Annette Sutherland, Box Elder	Governor	8/30/1993
Qualifications (if required): represents Elder Nutrition Program		
Ms. Lynn Paul, Bozeman	Governor	8/30/1993
Qualifications (if required): none specified		
Rep. Jim Rice, Helena	Governor	8/30/1993
Qualifications (if required): none specified		
Mr. Sid Rispens, Helena	Governor	8/30/1993
Qualifications (if required): none specified		
Mr. David Thomas, Helena	Governor	8/30/1993
Qualifications (if required): none specified		
Mr. Gary Watt, Helena	Governor	8/30/1993
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Aging Advisory Council (Governor)		
Ms. Dorothea C. Neath, Helena	Governor	7/18/1993
Qualifications (if required): member from Region IV		
Ms. Pauline Nikolaisen, Kalispell	Governor	7/18/1993
Qualifications (if required): member from Region IV		
Ms. Mary Alice Rehbein, Lambert	Governor	7/18/1993
Qualifications (if required): member from Region I		
Agriculture Development Council (Agriculture)		
Ms. Julie Burke, Glasgow	Governor	7/1/1993
Qualifications (if required): active in agriculture		
Mr. John W. Morse Jr., Dillon	Governor	7/1/1993
Qualifications (if required): active in agriculture		
Mr. John Swanz, Judith Gap	Governor	7/1/1993
Qualifications (if required): active in agriculture		
Alfalfa Leaf Cutting Bee Advisory Council (Agriculture)		
Mr. Tim Wetstein, Joliet	Governor	7/1/1993
Qualifications (if required): member of alfalfa seed growers		
American Indian Monument and Tribal Circle of Flags (Commerce)		
Mr. Deane Blanton, Helena	Governor	6/30/1993
Qualifications (if required): rep. Dept. of Administration, Architecture & Engineering Division		
Rep. Floyd "Bob" Gervais, Browning	Governor	6/30/1993
Qualifications (if required): represents Blackfeet Tribe		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
American Indian Monument and Tribal Circle of Flags (Commerce) cont.		
Mr. James King, Sr., Lame Deer	Governor	6/30/1993
Qualifications (if required): represents Northern Cheyenne Tribe		
Mr. Warren Matte, Harlem	Governor	6/30/1993
Qualifications (if required): represents Gros Ventre & Assiniboine Tribes		
Mr. Dave Schwab, Helena	Governor	6/30/1993
Qualifications (if required): represents Montana Historical Society		
Mr. Caleb Shields, Poplar	Governor	6/30/1993
Qualifications (if required): represents Assiniboine and Sioux Tribes		
Ms. Nelvette Siemion, Crow Agency	Governor	6/30/1993
Qualifications (if required): represents Crow Tribe		
Mr. Duncan Standing Rock, Sr., Box Elder	Governor	6/30/1993
Qualifications (if required): represents Chippewa-Cree Tribe		
Mr. Nicholas Peterson Vrooman, Helena	Governor	6/30/1993
Qualifications (if required): represents Montana Arts Council		
Mr. Tim Zimmerman, Havre	Governor	6/30/1993
Qualifications (if required): represents Little Shell Tribe		
Board of Banking (Commerce)		
Mr. C. David Bliss, Conrad	Governor	7/1/1993
Qualifications (if required): public member		
Mr. Jack Hensley, Kalispell	Governor	7/1/1993
Qualifications (if required): officer of state bank		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Board of Barbers (Commerce)		
Sergeant James Thul, Great Falls Qualifications (if required): barber	Governor	7/1/1993
Mr. Robert L. "Lanny" White, Townsend Qualifications (if required): public member	Governor	7/1/1993
Board of Cosmetologists (Commerce)		
Ms. Janet Markle, Glasgow Qualifications (if required): public member	Governor	7/1/1993
Mr. Scott Stekly, Great Falls Qualifications (if required): 1 of 3 licensed cosmetologists	Governor	7/1/1993
Board of Directors, Montana Self Insurers Guaranty Fund (Administration)		
Mr. Charles J. Gilder, Butte Qualifications (if required): none specified	Governor	7/1/1993
Mr. Donald E. Jenkins, Great Falls Qualifications (if required): none specified	Governor	7/1/1993
Mr. Donald Mizner, Missoula Qualifications (if required): none specified	Governor	7/1/1993
Board of Hearing Aid Dispensers (Commerce)		
Mr. Ben Havdahl, Helena Qualifications (if required): public member	Governor	7/1/1993
Mr. Walter Hopkins, Great Falls Qualifications (if required): hearing aid dispenser	Governor	7/1/1993

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Board of Landscape Architects (Commerce)		
Mr. Bruce F. Lutz, Kalispell	Governor	7/1/1993
Qualifications (if required): licensed landscape architect		
Mr. Tom Selstad, Great Falls	Governor	7/1/1993
Qualifications (if required): public member		
Board of Morticians (Commerce)		
Mr. John Patrick Hoffman, Havre	Governor	7/1/1993
Qualifications (if required): licensed mortician		
Board of Nursing (Commerce)		
Ms. Elizabeth Campo, Great Falls	Governor	7/1/1993
Qualifications (if required): 1 of 4 registered professional nurses		
Board of Pharmacy (Commerce)		
Ms. Diana M. Pennell, Lewistown	Governor	7/1/1993
Qualifications (if required): public member		
Board of Physical Therapy Examiners (Commerce)		
Ms. Joyce Dougan, Missoula	Governor	7/1/1993
Qualifications (if required): physical therapist		
Board of Private Security Patrolmen and Investigators (Commerce)		
Colonel Robert Griffith, Helena	Governor	8/1/1993
Qualifications (if required): member/Peace Officers Standards & Training Advisory Council		
Ms. Gay Ann Masolo, Townsend	Governor	8/1/1993
Qualifications (if required): public member		
Board of Public Accountants (Commerce)		
Mr. Marvin Stephens, Lewistown	Governor	7/1/1993
Qualifications (if required): certified public accountant		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Board of Radiologic Technologists (Commerce)		
Ms. Robin Anderson, Bozeman	Governor	7/1/1993
Qualifications (if required): radiologic technologist		
Ms. Debra Metz, Big Arm	Governor	7/1/1993
Qualifications (if required): public member		
Ms. Debbie Sanford, Lewistown	Governor	7/1/1993
Qualifications (if required): limited permit radiologic technologist		
Dr. J.D. "Jerry" Wolf, Billings	Governor	7/1/1993
Qualifications (if required): medical doctor		
Board of Regents (Education)		
Mr. Travis M. Belcher, Helena	Governor	6/1/1993
Qualifications (if required): student at unit of higher education jurisdiction of board of regents		
Board of Sanitarians (Commerce)		
Mr. Danny Corti, Missoula	Governor	7/1/1993
Qualifications (if required): licensed sanitarian & not a public member		
Mr. Donald E. Sampson, Missoula	Governor	7/1/1993
Qualifications (if required): public member		
Board of Veterinary Medicine (Commerce)		
Ms. Anne Johnson, Malta	Governor	7/31/1993
Qualifications (if required): licensed veterinarian		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Burial Preservation Board (Commerce)		
Dr. Tom Foor, Missoula	Governor	8/22/1993
Qualifications (if required): rep. from Montana State Historic Preservation Office		
Mr. Carl Fourstar, Poplar	Governor	8/22/1993
Qualifications (if required): rep. Assiniboine and Sioux Tribes		
Mr. Pat Lefthand, Pablo	Governor	8/22/1993
Qualifications (if required): rep. Salish & Kootenai Tribes		
Mr. Jay Stovall, Billings	Governor	8/22/1993
Qualifications (if required): public member		
Mr. William Tallbull, Buzby	Governor	8/22/1993
Qualifications (if required): rep. Northern Cheyenne Tribe		
Mr. Clarence "Curly Bear" Wagner, Browning	Governor	8/22/1993
Qualifications (if required): rep. Blackfeet Tribe		
Chemical Dependency Advisory Council (Corrections & Human Services)		
Representative Steve Benedict, Hamilton	Director	7/1/1993
Qualifications (if required): none specified		
Mr. Gene Bukowski, Billings	Director	7/1/1993
Qualifications (if required): none specified		
Ms. Carole Carey, Ekalaka	Director	7/1/1993
Qualifications (if required): none specified		
Ms. Dana L. Christensen, Kalispell	Director	7/1/1993
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Chemical Dependency Advisory Council (Corrections & Human Services) cont.		
Mr. Terry Dennis, Billings Qualifications (if required): none specified	Director	7/1/1993
Mr. Jim Gamell, Great Falls Qualifications (if required): none specified	Director	7/1/1993
Ms. Carol Judge, Helena Qualifications (if required): none specified	Director	7/1/1993
Ms. Sandra Lambert, Miles City Qualifications (if required): none specified	Director	7/1/1993
Mr. Marko Lucich, Butte Qualifications (if required): none specified	Director	7/1/1993
Mr. Curtis C. Moxley, Chinook Qualifications (if required): none specified	Director	7/1/1993
Child Care Advisory Council (Social and Rehabilitation Services)		
Ms. Peggy Baraby, Helena Qualifications (if required): represent state agency	Governor	6/30/1993
Mr. Hugh Brown, Chester Qualifications (if required): parent representative	Governor	6/30/1993
Ms. Gayle Carpenter, Helena Qualifications (if required): public member	Governor	6/30/1993
Ms. Colleen McGuire, Deer Lodge Qualifications (if required): public member	Governor	6/30/1993

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Child Care Advisory Council (Social and Rehabilitation Services) cont.		
Ms. Linda Patrick, Helena	Governor	6/30/1993
Qualifications (if required): represents state agency		
Ms. Mary Jo Simpkins, Great Falls	Governor	6/30/1993
Qualifications (if required): parent representative		
Ms. Susan Skinner, Helena	Governor	6/30/1993
Qualifications (if required): represents state agency		
Commission on Uniform State Laws (Governor)		
Mr. Ed Eck, Missoula	Governor	7/1/1993
Qualifications (if required): recog. bar member or faculty of state university law school		
Joseph P. Mazurek, Helena	Governor	7/1/1993
Qualifications (if required): none specified		
Mr. James E. Vidal, Kalispell	Governor	7/1/1993
Qualifications (if required): recog. bar member or faculty of state university law school		
Committee on Telecommunication Services for the Handicapped (Social and Rehabilitation Services)		
Mr. Ralph Foster, Joplin	Governor	7/1/1993
Qualifications (if required): member who is handicapped		
Ms. Joan Mandeville, Helena	Governor	7/1/1993
Qualifications (if required): member of independent local exchange		
Ms. Rebecca Plaggemeyer, Helena	Governor	7/1/1993
Qualifications (if required): member of an InterLATA carrier		
Mr. Edward G. VanTighem, Great Falls	Governor	7/1/1993
Qualifications (if required): handicapped-deaf or hard of hearing		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Electrical Board (Commerce)		
Mr. Kenneth Olsen, Billings	Governor	7/1/1993
Qualifications (if required): none specified		
Family Support Services Advisory Council (Social and Rehabilitation Services)		
Ms. Linda Botten, Bozeman	Governor	6/30/1993
Qualifications (if required): none specified		
Ms. Sylvia Danforth, Miles City	Governor	6/30/1993
Qualifications (if required): none specified		
Dr. Rowena Foos, Billings	Governor	6/30/1993
Qualifications (if required): none specified		
Ms. Sue Forest, Missoula	Governor	6/30/1993
Qualifications (if required): none specified		
Ms. Margaret Grogan, Great Falls	Governor	6/30/1993
Qualifications (if required): none specified		
Senator Ethel M. Harding, Polson	Governor	6/30/1993
Qualifications (if required): none specified		
Ms. Beth Kenny, Helena	Governor	6/30/1993
Qualifications (if required): none specified		
Mr. John Madsen, Helena	Governor	6/30/1993
Qualifications (if required): none specified		
Mr. Ted Maloney, Missoula	Governor	6/30/1993
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Family Support Services Advisory Council (Social and Rehabilitation Services) cont.		
Ms. Sandi Marisdotter, Helena Qualifications (if required): none specified	Governor	6/30/1993
Mr. Dan McCarthy, Helena Qualifications (if required): none specified	Governor	6/30/1993
Ms. Jeanette McCormick, Choteau Qualifications (if required): none specified	Governor	6/30/1993
Mr. Pete Surdock, Jr., Helena Qualifications (if required): none specified	Governor	6/30/1993
Ms. Judy Wright, Helena Qualifications (if required): none specified	Governor	6/30/1993
Historical Society Board of Trustees (Education)		
Mr. John Burke, Butte Qualifications (if required): public member	Governor	7/1/1993
Mr. Stuart W. Conner, Billings Qualifications (if required): none specified	Governor	7/1/1993
Mr. William M. Holt, Lolo Qualifications (if required): recognized archeologist	Governor	7/1/1993
Ms. Helen L. Hornby, Livingston Qualifications (if required): none specified	Governor	7/1/1993

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Incentive Awards Advisory Council (Administration)		
Mr. Jim Adams, Helena	Director	7/1/1993
Qualifications (if required): general public member		
Ms. Ann Bartel, Great Falls	Director	7/1/1993
Qualifications (if required): general public member		
Ms. Laurie Ekanger, Clancy	Director	7/1/1993
Qualifications (if required): ex-officio non-voting member		
Mr. Jack Ellery, Helena	Director	7/1/1993
Qualifications (if required): state employee		
Ms. Renee Erdmann, Helena	Director	7/1/1993
Qualifications (if required): state employee		
Mr. Russell G. McDonald, Helena	Director	7/1/1993
Qualifications (if required): state employee		
Ms. Lois A. Menzies, Helena	Director	7/1/1993
Qualifications (if required): state employee		
Ms. Janet Myren, Helena	Director	7/1/1993
Qualifications (if required): state employee		
Mr. John H. Noble, Helena	Director	7/1/1993
Qualifications (if required): state employee		
Joint Committee on Postsecondary Education Policy & Budget (Education)		
Ms. Marilyn Miller, Helena	Governor	7/1/1993
Qualifications (if required): member of executive branch		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Judicial Standards Commission (Judicial)		
Mr. Marvin Cowdrey, Bozeman	Governor	7/1/1993
Qualifications (if required): none specified		
Judge Mark P. Sullivan, Butte	elected	6/30/1993
Qualifications (if required): none specified		
Mr. Victor F. Valgenti, Missoula	Supreme Court	6/30/1993
Qualifications (if required): none specified		
MIAMI Project Advisory Council (Health and Environmental Sciences)		
Ms. Lil Anderson, Billings	Governor	6/30/1993
Qualifications (if required): local service provider		
Ms. Nancy Colton, Bozeman	Governor	6/30/1993
Qualifications (if required): representative of parent organization		
Ms. Marietta Cross, Missoula	Governor	6/30/1993
Qualifications (if required): representative of non profit child health organization		
Mr. Dan Dennehy, Butte	Governor	6/30/1993
Qualifications (if required): rep. of local health department		
Ms. Nancy Ellery, Helena	Governor	6/30/1993
Qualifications (if required): representative from SRS supervise services MT Medicaid		
Dr. Jeffrey P. Hinz, Great Falls	Governor	6/30/1993
Qualifications (if required): obstetrician/pediatrician		
Rep. Angela Russell, Lodge Grass	Governor	6/30/1993
Qualifications (if required): American Indian		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
MIAMI Project Advisory Council (Health and Environmental Sciences) cont.		
Mr. Dale Taliaferro, Helena	Governor	6/30/1993
Qualifications (if required): from dept. provides preventive health services for women & child		
Mental Disabilities Board of Visitors (Governor)		
Ms. Pat Aanrud, Lewistown	Governor	8/1/1993
Qualifications (if required): consumer		
Ms. Arlene Breum, Missoula	Governor	8/1/1993
Qualifications (if required): mental disabilities representative		
Ms. Marjorie Fehrer, Bozeman	Governor	8/1/1993
Qualifications (if required): consumer member		
Mr. Wallace A. King, Helena	Governor	8/1/1993
Qualifications (if required): professional		
Ms. Lanelle Petersen, Brady	Governor	8/1/1993
Qualifications (if required): consumer from Developmentally Disabled Board		
Mr. Robert W. Visscher, Livingston	Governor	8/1/1993
Qualifications (if required): professional		
Microbusiness Finance Program Advisory Council (Commerce)		
Mr. Harold J. Fraser, Missoula	Governor	8/21/1993
Qualifications (if required): represents banking industry		
Mr. Richard T. Greenshields, East Glacier Park	Governor	8/21/1993
Qualifications (if required): represents cities with population under 15,000		
Mr. Donald C. Ingels, Miles City	Governor	8/21/1993
Qualifications (if required): represents cities with population under 15,000		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Microbusiness Finance Program Advisory Council (Commerce) cont.		
Ms. Judith Johnston, Helena	Governor	8/21/1993
Qualifications (if required): represents microbusiness owners		
Ms. Jeanne Moeller, Billings		8/21/1993
Qualifications (if required): represents cities with population greater than 15,000		
Mr. Richard C. King, Chinook	Governor	8/21/1993
Qualifications (if required): expertise in revolving loan fund administration		
Montana Health Facility Authority Board (Commerce)		
Dr. Amos Little, Helena	Governor	7/29/1993
Qualifications (if required): none specified		
Montana Mint Committee (Agriculture)		
Mr. Brian Schweitzer, Whitefish	Governor	7/1/1993
Qualifications (if required): active mint grower		
Motorcycle Safety Advisory Committee (Office of Public Instruction)		
Ms. Anita Drews, East Helena	Attorney General	7/1/1993
Qualifications (if required): represents Department of Justice		
Ms. Pat Wherley, Three Forks	Governor	7/1/1993
Qualifications (if required): motorcycle rider representing motorcycle riding groups		
Noxious Weed Advisory Council (Agriculture)		
Mr. P.L. "Joe" Boyd, Billings	Director	6/30/1993
Qualifications (if required): consumer group		
Mr. Dane Castleberry, Ekalaka	Director	6/30/1993
Qualifications (if required): livestock production		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Noxious Weed Advisory Council (Agriculture) cont.		
Rep. Fred "Fritz" Daily, Butte	Director	6/30/1993
Qualifications (if required): council chairman		
Ms. Candace Durran, Helena	Director	6/30/1993
Qualifications (if required): sportsman/wildlife group		
Ms. Mercy Knowlton, Poplar	Director	6/30/1993
Qualifications (if required): Agriculture Crop Production		
Mr. Lonnie McCurdie, Conrad	Director	6/30/1993
Qualifications (if required): At-Large Member		
Mr. Wayne Pearson, Absarokee	Director	6/30/1993
Qualifications (if required): Montana Weed Control Association		
Rep. Bob Thoft, Stevensville	Director	6/30/1993
Qualifications (if required): Biological Research & Control		
Mr. Thomas A. Wood, Joplin	Director	6/30/1993
Qualifications (if required): Herbicide Dealer & Applicator		
Petroleum Tank Release Compensation Board (Health and Environmental Sciences)		
Mr. Ray Blehm, Helena	Governor	6/30/1993
Qualifications (if required): State Fire Marshall		
Mr. Donald E. Pizzini, Great Falls	Governor	6/30/1993
Qualifications (if required): Director of Department of Health & Environmental Sciences		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Public Vehicle Fueling Advisory Council (Administration)		
Ms. Ronna Alexander, Bozeman	Governor	6/30/1993
Qualifications (if required): none specified		
Mr. Bob Anderson, Helena	Governor	6/30/1993
Qualifications (if required): none specified		
Mr. Bill Ballard, Butte	Governor	6/30/1993
Qualifications (if required): none specified		
Mr. Bruce Barrett, Helena	Governor	6/30/1993
Qualifications (if required): representative of Department of Transportation		
Mr. Larry Blades, Joliet	Governor	6/30/1993
Qualifications (if required): none specified		
Mr. Bob Blyth, Butte	Governor	6/30/1993
Qualifications (if required): none specified		
Ms. Donna Campbell, Helena	Governor	6/30/1993
Qualifications (if required): none specified		
Mr. Russ Fillner, Helena	Governor	6/30/1993
Qualifications (if required): none specified		
Mr. John Geach, Helena	Governor	6/30/1993
Qualifications (if required): none specified		
Ms. Beverly Gibson, Helena	Governor	6/30/1993
Qualifications (if required): none specified		
Ms. Gail Gray, Helena	Governor	6/30/1993
Qualifications (if required): none specified		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Public Vehicle Fueling Advisory Council (Administration) cont.		
Ms. Donna Hall, Great Falls Qualifications (if required): none specified	Governor	6/30/1993
Mr. Alec Hansen, Helena Qualifications (if required): none specified	Governor	6/30/1993
Mr. Kurt Hilyard, Fort Benton Qualifications (if required): none specified	Governor	6/30/1993
Mr. Bob Marks, Helena Qualifications (if required): none specified	Governor	6/30/1993
Mr. Randy Mosely, Helena Qualifications (if required): none specified	Governor	6/30/1993
Mr. Ed Robinson, Helena Qualifications (if required): none specified	Governor	6/30/1993
Mr. William S. Rose, Bozeman Qualifications (if required): none specified	Governor	6/30/1993
Mr. Howard Wheatley, Great Falls Qualifications (if required): none specified	Governor	6/30/1993
Special Education Advisory Council (Office of Public Instruction)		
Rep. Bob Bachini, Havre Qualifications (if required): legislator	Superintendent of Schools	7/1/1993
Ms. Sherry Bock, Great Falls Qualifications (if required): teacher of children with handicapping conditions	Superintendent of Schools	7/1/1993

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Special Education Advisory Council (Office of Public Instruction) cont.		
Mr. James F. Canan, Billings	Superintendent of Schools	7/1/1993
Qualifications (if required): parent of child with handicapping condition		
Mr. Mike Hanshew, Helena	Superintendent of Schools	7/1/1993
Qualifications (if required): state agency		
Ms. Betty Jo Vance, Helena	Superintendent of Schools	7/1/1993
Qualifications (if required): deaf/blind representative		
Teachers' Retirement Board (Administration)		
Ms. Verna Green, Helena	Governor	7/1/1993
Qualifications (if required): public member		
Ms. Nancy Keenan, Helena	Governor	7/1/1993
Qualifications (if required): Superintendent of Public Instruction		
Mr. John Kranick, Great Fall	Governor	7/1/1993
Qualifications (if required): retired teacher		
Ms. Nancy B. Trackwell, Great Falls	Governor	7/1/1993
Qualifications (if required): public member		
Tourism Advisory Council (Commerce)		
Mr. Arnold D. "Smoke" Elser, Missoula	Governor	7/1/1993
Qualifications (if required): from Glacier Country		
Mr. Ken Hoovestol, Great Falls	Governor	7/1/1993
Qualifications (if required): from Russell Country		
Mr. Richard D. Krott, Helena	Governor	7/1/1993
Qualifications (if required): from Gold West Country		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Tourism Advisory Council (Commerce) cont.		
Mr. Larry McRae, Kalispell Qualifications (if required): from Glacier Country	Governor	7/1/1993
Water Plan Advisory Council (Natural Resources and Conservation)		
Mr. Joe Aldegarie, Missoula Qualifications (if required): none specified	Governor	7/25/1993
Senator Esther Bengtson, Shepherd Qualifications (if required): none specified	Governor	7/25/1993
Mr. Stan Bradshaw, Helena Qualifications (if required): none specified	Governor	7/25/1993
Ms. Ana Brenden, Scobey Qualifications (if required): none specified	Governor	7/25/1993
Mr. Jay Chamberlain, Dillon Qualifications (if required): none specified	Governor	7/25/1993
Ms. Connie Cole, Helena Qualifications (if required): none specified	Governor	7/25/1993
Mr. Jack Galt, Martinsdale Qualifications (if required): none specified	Governor	7/25/1993
Mr. Pat Graham, Helena Qualifications (if required): none specified	Governor	7/25/1993
Mr. Dennis Iverson, Helena Qualifications (if required): none specified	Governor	7/25/1993

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Water Plan Advisory Council (Natural Resources and Conservation) cont.		
Rep. Tom Lee, Bigfork	Governor	7/25/1993
Qualifications (if required): none specified		
Mr. Glenn Marx, Helena	Governor	7/25/1993
Qualifications (if required): none specified		
Mr. Don Pfau, Lewistown	Governor	7/25/1993
Qualifications (if required): none specified		
Mr. Jerald Sorensen, Polson	Governor	7/25/1993
Qualifications (if required): none specified		
Mr. John Wardell, Helena	Governor	7/25/1993
Qualifications (if required): none specified		
Mr. Jim Wedeward, Billings	Governor	7/25/1993
Qualifications (if required): none specified		
Western Interstate Commission for Higher Education (Governor)		
Dr. John Hutchinson, Helena	Governor	6/19/1993
Qualifications (if required): commissioner of higher education		
Wheat and Barley Committee (Agriculture)		
Mr. Ernest Bahnmiller, Big Sandy	Governor	8/20/1993
Qualifications (if required): resides in District IV & affiliated with Republican Party		
Mr. Jim Squires, Glendive	Governor	8/20/1993
Qualifications (if required): producer from District VII		

VACANCIES ON BOARDS AND COUNCILS -- June 1, 1993 through August 31, 1993

Board/current position holder	Appointed by	Term end
Women in Employment Advisory Council (Governor)		
Ms. Jeanne Amsberry, Helena Qualifications (if required): none specified	Governor	8/9/1993
Ms. Judy Birch, Helena Qualifications (if required): none specified	Governor	8/9/1993
Ms. Virginia Bliss, Conrad Qualifications (if required): none specified	Governor	8/9/1993
Ms. Aubyn Curtiss, Fortine Qualifications (if required): none specified	Governor	8/9/1993
Ms. Ilene Dallum, Cascade Qualifications (if required): none specified	Governor	8/9/1993
Ms. Dolores Havdahl, Helena Qualifications (if required): none specified	Governor	8/9/1993
Ms. Darlene Johnson, Wolf Point Qualifications (if required): none specified	Governor	8/9/1993
Ms. Carolyn Linden, Helena Qualifications (if required): none specified	Governor	8/9/1993
Ms. Carolyn Miller, Helena Qualifications (if required): none specified	Governor	8/9/1993
Ms. Blanche Proul, Anaconda Qualifications (if required): none specified	Governor	8/9/1993
Ms. Antoinette Fraser Rosell, Billings Qualifications (if required): none specified	Governor	8/9/1993

Board/current position holder	Appointed by	Term end
Women in Employment Advisory Council (Governor)	cont.	
Ms. Sue Weingartner, Helena	Governor	8/9/1993
Qualifications (if required): none specified		