CHAPTER 45-02-02
LICENSING OF INSURANCE PRODUCERS, SURPLUS LINES INSURANCE PRODUCERS, AND CONSULTANTS

45-02-02-01. Definitions.

Unless otherwise defined, or made inappropriate by context, all words used in this chapter have meaning as given them under North Dakota Century Code chapter 26.1-26. "Department" means North Dakota insurance department.

History: Effective September 1, 1983; amended effective April 1, 2010.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-02

45-02-02-02. Applications for licenses.

1. **Resident insurance producers' applications.**

   a. ~~An~~ A complete application must be completed in accordance with the instruction sheet and submitted either electronically or with a paper filing on a commissioner-approved application form.

   b. An applicant licensed in another state within the preceding ninety days who moves to this state must provide, with the application, proof of clearance from the state in which the insurance producer is currently or was most recently licensed as a resident insurance producer.

   c. An application form is required to add an additional line of insurance.

   d. Every application submitted to the department through either a paper or electronic filing must be accompanied by the appropriate fee made payable to either the commissioner or the commissioner's designee.

2. **Nonresident insurance producers' applications.**

   a. ~~An~~ A complete application for a nonresident insurance producer's license must comply with subdivisions a, c, and d of subsection 1 and must contain a written designation of the commissioner and the commissioner's successors in office as that insurance producer's true and lawful attorney for purposes of service of process.

   b. An applicant for a nonresident insurance producer's license must have the state, which issued the agent's resident license, supply to the department a certificate showing the lines for which the agent is licensed and eligible to write in that state. This certification may be submitted by the national association of insurance commissioners' producer data base.

3. **Surplus lines insurance producers' applications.** A surplus lines insurance producer's application must be submitted in accordance with chapter 45-09-01.

4. **Consultants' applications.**

   a. An application for a consultant's license must be submitted in accordance with the instruction sheet provided by the department and submitted on the appropriate form.

   b. No person holding a license as an insurance producer or surplus lines insurance producer may obtain and simultaneously hold a license as a consultant. If the applicant holds such licenses at the time of application, the licenses must be canceled prior to obtaining a consultant's license.

5. **Temporary license applications.**

   a. An application for a temporary insurance producer's license must be submitted in accordance with section 45-02-02-02.

   b. The application must be accompanied by a written statement of the reasons for requesting the issuance of a temporary license.

   c. A temporary license will not be granted for the sole reason that the applicant has failed to pass the insurance producers' examination and desires to be licensed until such time as a passing examination score is obtained.

History: Effective September 1, 1983; amended effective October 1, 1984; January 1, 1987; April 1, 1996; January 1, 2000; December 1, 2001; January 1, 2008; January 1, 2016; October 1, 2019.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-12, 26.1-26-13

45-02-02-03. Examination for licensure.

1. An applicant must qualify for a line of authority by passing the examination as provided in this chapter.

2. The examination is administered under a contract with a testing service.

3. An applicant must present a photo identification card at the test center prior to being admitted for testing.

4. An examination score is valid for one year after the date of the examination for a license applicant who has not completed the application process and who has not obtained licensure. After one year from the date of the examination, an applicant must retake the required examination.

5. An examination is valid for as long as a person continuously holds a valid insurance producer's license issued by the North Dakota insurance department and for twelve months following cancellation of a license, with the exception that an examination ceases to be valid immediately upon the suspension or revocation of the license unless the order of suspension or revocation specifies otherwise.

History: Effective September 1, 1983; amended effective October 1, 1984; January 1, 2000; December 1, 2001; January 1, 2008; April 1, 2010.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-14, 26.1-26-27

45-02-02-04. Specific examination requirements.

1. An applicant applying to conduct insurance in the following lines must pass the following examinations:

   a . Life and annuity Life and annuity

   b . Accident and health Accident and health

   c . Property Property

   d . Casualty Casualty

   e . Variable life and annuity Life and annuity

2. An applicant applying for a license for title insurance is exempt from any examination requirement but must meet the following qualifications:

   a. The applicant must be a licensed abstracter or attorney; or

   b. The applicant must have a minimum of eighty hours of training provided by an insurer licensed in the line of title insurance. A certification by the insurer that the training has been completed must accompany the application.

3. An applicant for a license to write travel and baggage insurance coverage for trip cancellation, trip interruption, baggage, life, sickness and accident, disability, and personal effects when limited to a specific trip and sold in connection with transportation provided by a common carrier is exempt from examination requirements.

4. An applicant for a license with the line of authority of surety shall take and pass the casualty examination. Surety coverage is insurance or a bond that covers obligations to pay the debts of or answer for the default of another, including faithlessness in a position of public or private trust, but not including bail bonds.

5. An applicant for a license to write the following products need only take the reduced examination required for that specific product:

   a. Bail bonds.

   b. Credit including credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the insurance commissioner determines should be designated a form of credit insurance.

c. Crop or crop hail. Crop or crop hail insurance is insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease or other yield-reducing conditions, or perils provided by the private insurance market, or that is subsidized by the federal crop insurance corporation, including multiperil crop insurance.

d. Legal expense, including prepaid legal service.

e. Personal lines. Personal lines is property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

6. An applicant for a consultant's license shall take and pass the insurance producer's examination for the lines in which the applicant seeks to consult. If an applicant for a consultant's license holds a North Dakota insurance producer's license, the applicant is exempt from the testing requirements for the lines held on the insurance producer's license within the twelve months preceding the date on which the consultant application is filed with the commissioner. However, the applicant must cancel the insurance producer's license prior to obtaining a consultant's license.

History: Effective September 1, 1983; amended effective October 1, 1984; January 1, 2000; December 1, 2001; January 1, 2008; April 1, 2010; January 1, 2016.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-25

45-02-02-05. Effective date of insurance producer license - New line.

1. An applicant who has filed a completed application for an insurance producer's license with the insurance department may first transact business under that license effective the date the applicant's application is approved by the insurance department.

2. An insurance producer who is adding a new line of insurance may first transact business in that new line effective the date the application is approved by the insurance department.

History: Effective September 1, 1983; amended effective October 1, 1984; January 1, 1987; January 1, 2000; December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-08, 26.1-26-12, 26.1-26-13, 26.1-26-32

45-02-02-05.1. Biennial license continuation.

On or before the last day of the month of the licensee's birthday following the two-year anniversary of the issuance of a license by the commissioner and every two years thereafter, an individual insurance producer shall submit an application for license continuation. Applications must be accompanied by the biennial continuation fee of twenty-five dollars. Resident insurance producers must have on file with the commissioner proof of compliance with continuing education requirements before submitting the application. Nonresident insurance producers must have satisfied the producer's home state's insurance continuing education requirements and be in good standing in the producer's home state before submitting the continuation application.

History: Effective April 1, 2010.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-13.4

45-02-02-05.2. Cancellation of license.

The license of an insurance producer who fails to complete the biennial continuation and pay the twenty-five dollar continuation fee will be canceled.

History: Effective April 1, 2010.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-13.4, 26.1-26-31

45-02-02-06. Appointment and termination procedures.

1. The appointment or termination of an insurance producer must be filed with the department on either a form prescribed by the commissioner or electronically through the national association of insurance commissioners' subsidiary. The insurer shall pay an appointment fee for each insurance producer appointed pursuant to North Dakota Century Code section 26.1-01-07.

2. An insurer shall file with the department a notice of appointment within thirty days from the later of the date the agency contract is executed or the first insurance application is submitted to the insurer. The date of the appointment must include the month, day, and year.

3. An insurer shall file the notice of termination of its agency relationship with an insurance producer within thirty days following the effective date of the termination. Terminations for cause shall be submitted to the department in accordance with the requirements of North Dakota Century Code section 26.1-26-34. The insurer is responsible for notifying the insurance producer of the termination in accordance with North Dakota Century Code section 26.1-26-34.

4. Failure to timely file appointment or termination notifications may subject an insurer to sanctions under North Dakota Century Code title 26.1.

History: Effective September 1, 1983; amended effective October 1, 1984; January 1, 2000; December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-08, 26.1-26-12, 26.1-26-13, 26.1-26-31, 26.1-26-32

45-02-02-07. Renewal procedure for appointments.

1. On or before December first of each year, a preliminary renewal list of the insurance producers appointed by that company, together with an instruction letter, will be furnished by the department to each company.

2. On or before March fifteenth of each year, an electronic renewal invoice will be made available through the national association of insurance commissioners' subsidiary to all companies with active appointments.

3. The insurer shall pay the appropriate fee for all appointments on the renewal invoice prior to May first.

History: Effective September 1, 1983; amended effective October 1, 1984; December 1, 2001; January 1, 2008.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-08, 26.1-26-32

45-02-02-07.1. License lapse.

Repealed effective December 1, 2001.

45-02-02-08. Agent - Sharing commission.

Repealed effective December 1, 2001.

45-02-02-09. Insurance consultant - Agreement.

In advance of rendering any service as a consultant, such consultant shall prepare a form of written agreement which shall substantially comply with the model form available on request from the insurance department. The form prepared by the consultant shall be submitted to the department for the commissioner's approval or disapproval. If the commissioner disapproves the form, the consultant shall not use the form so disapproved.

In advance of rendering any service as a consultant, a written agreement on the form which has been approved by the department shall be signed by both consultant and client. The consultant shall retain a copy of the agreement for not less than two years after completion of the services. A copy of the agreement shall be available to the department upon request.

History: Effective September 1, 1983.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-03, 26.1-26-10, 26.1-26-35

45-02-02-10. Insurance producer and surplus lines insurance producer acting as consultant.

Although licensed insurance producers or surplus lines insurance producers are exempt from licensing as consultants and are specifically prohibited from concurrently holding a consultant's license and a license as an insurance producer or surplus lines insurance producer in any line, licensed insurance producers or surplus lines insurance producers may perform consulting services in the ordinary course of their businesses. However, if licensed insurance producers or surplus lines insurance producers charge a fee, or receive any type of remuneration, for rendering such consulting service, they shall comply with the provisions and requirements of a consultant's agreement set forth in section 45-02-02-09.

History: Effective September 1, 1983; amended effective December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-35

45-02-02-11. Insurance producers selling variable life and annuity contracts.

In addition to the requirements set forth in section 45-02-02-03, an applicant for a license to do business in the variable life and annuity line must first become licensed as a securities salesman under North Dakota law.

History: Effective September 1, 1983; amended effective October 1, 1984; January 1, 2000; December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-11

45-02-02-12. Administrative cancellations.

1. An insurance producer may cancel one's North Dakota insurance license voluntarily and have a letter of clearance issued by filing a written request with the department.

2. The insurance producer must return the licenses to the department.

3. The insurance producer is responsible for notifying the appointing companies of the cancellation.

4. A surplus lines insurance producer or consultant may cancel one's license voluntarily and have a letter of clearance issued by the department upon receipt of a written request from the licenseholder.

History: Effective September 1, 1983; amended effective January 1, 2000; December 1, 2001; January 1, 2016.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-31

45-02-02-13. Change of address.

The change of address required by North Dakota Century Code section 26.1-26-33 must be provided to the department electronically or on a letter or form separate from the application or appointment forms and submitted solely for that purpose.

History: Effective September 1, 1983; amended effective October 1, 1984; January 1, 2008.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-33

45-02-02-14. Excessive or unnecessary coverage.

1. **When presumed a violation.** An insurance producer is presumed to have violated subsection 8 of North Dakota Century Code section 26.1-26-42 when the insurance producer knowingly solicits, procures, or sells a medicare supplement policy containing both A and B coverage to any person who has such a medicare supplement policy in force unless the insured is informed by the insurance producer and understands there is to be a replacement of the existing policy and there is an indication in writing or on the face of the application that the new policy is intended to replace the existing policy. It is not presumed to be a violation to solicit and sell a second policy which provides only B coverage. A violation may occur in other situations where there is the sale or solicitation of unnecessary or excessive coverage, even though no presumption has been established under this section.

2. **Suitability.** In recommending the purchase of any accident and health, health service, life, annuity, or nursing home policy to any consumer over age sixty-five, or medicare supplement policy to any consumer, an insurance producer shall have reasonable grounds at the time of sale for believing that the recommendation is suitable for the consumer and shall make reasonable inquiries to determine suitability. The suitability of a recommended purchase of insurance will be determined by examination of the totality of the particular consumer's circumstances, including, but not limited to, the following:

   a. The consumer's income and assets;

   b. The consumer's need for insurance at the time of sale; and

   c. The values, benefits, and costs of the consumer's existing insurance program, if any, when compared to the values, benefits, and costs of the recommended policy or policies.

3. **Advisory committee.** Prior to determining whether to prosecute a complaint received for an alleged violation of the sale of life insurance under subsection 2 of section 45-02-02-14, the commissioner shall convene an advisory committee comprised of insurance professionals and other qualified persons to review individual life insurance sales transactions and to make recommendations to appropriate staff of the insurance department regarding the suitability of the sale and whether disciplinary action may be warranted by the facts if proven. The advisory committee shall include the president of the North Dakota association of insurance and financial advisors or the president's designated representative, the president of the North Dakota chapter of chartered life underwriters or the president's designated representative and may include a member designated by the board of the local chapter of the North Dakota association of insurance and financial advisors which is located nearest to the residence of the insurance producer who is the subject of the complaint.

History: Effective October 1, 1984; amended effective July 1, 1986; January 1, 1988; February 1, 1988; December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-42

45-02-02-14.1. Client loans to licensed producers and consultants prohibited - Exceptions.

A licensed insurance producer or consultant may not solicit or accept a loan from an individual with whom the insurance producer or consultant came into contact in the course of the person's insurance business, or sold an insurance policy to, within the past ten years. This does not prohibit a licensed insurance producer or consultant from accepting loans from financial institutions; immediate family members, which shall mean only a spouse, parents, siblings, and children; or other loans upon the prior written approval of the insurance commissioner.

History: Effective November 1, 1987; amended effective December 1, 2001.
General Authority: NDCC 26.1-25-49
Law Implemented: NDCC 26.1-26-42(6)

45-02-02-14.2. Insurance producer indebtedness to companies.

An insurance producer who is personally liable and indebted to an insurance company for the payment of commissions, premiums, or other debts incurred in the insurance producer's insurance business with the company and who fails to timely pay that debt is financially irresponsible within the meaning of subsection 6 of North Dakota Century Code section 26.1-26-42. A civil judgment entered against an insurance producer in favor of an insurance company for the collection of such a debt creates a presumption that subsection 6 of North Dakota Century Code section 26.1-26-42 has been violated.

History: Effective November 1, 1987; amended effective December 1, 2001.
General Authority: NDCC 26.1-25-49
Law Implemented: NDCC 26.1-26-42(6)

45-02-02-15. Proceedings, hearings, and appeals.

All proceedings, hearings, and appeals under this chapter and North Dakota Century Code chapter 26.1-26 are governed by North Dakota Century Code chapter 28-32.

History: Effective October 1, 1984.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-01-08

45-02-02-16. Notification of criminal convictions and administrative actions - Duty of licensee.

Repealed effective December 1, 2001.

CHAPTER 45-05-09
DEFENSE EXPENSES WITHIN THE LIMIT OF LIABILITY PROVISIONS

45-05-09-01. Defense expenses within limit of liability provisions - Exceptions.

1. No admitted insurer shall issue or renew a policy of liability insurance in this state that includes defense expenses within the limit of liability unless the policy's minimum limit per occurrence or the aggregate liability limit for all liability risks and coverages under the policy is at least:

   a. One million dollars for primary coverages; and

   b. One hundred thousand dollars for secondary coverages.

2. No admitted insurer shall issue or renew a policy of liability insurance in this state that includes defense expense allowance provision unless the policy's minimum limit per occurrence or the aggregate liability limit for all liability risks and coverages under the policy is at least:

   a. Three hundred thousand dollars for damages and one hundred thousand dollars for defense for primary coverages except medical malpractice and legal malpractice;

      1. Three hundred thousand dollars for damages and fifty thousand dollars for defense for primary coverages for legal malpractice only;

      2. One million dollars for defense for primary coverages for medical malpractice; and

   b. One hundred thousand dollars for either damages or defense for secondary coverages.

"Primary coverages" means the main or intended coverage of the policy.

"Secondary coverages" means coverage which is in addition to the main policy by endorsement, rider, or additional coverages.

History: Effective April 1, 2015; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-04-02

45-05-09-02. Policies within which defense expenses within limit of liability permitted.

Defense expenses within the limit of liability provisions are allowed only within the following types of policies or coverages within a policy with the limits of liability as required in section 45-05-09-01:

1. Cyber liability;
2. Fiduciary liability;
3. Directors and officers liability;
4. Errors and omissions liability;
5. Employer practices liability;

6. Medical malpractice liability;
7. Pollution liability;
8. Liquor liability;
9. Nuclear liability;
10. Fidelity bond;
11. Umbrella and excess policies; and
12. Other policies permitted within the discretion of the insurance commissioner.

History: Effective April 1, 2015.

General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-04-02

45-05-09-03. Notice required.

The fact that defense expenses are within the limit of liability or defense costs are limited by an allowance must be disclosed on the declaration page in at least twelve-point bold print.

History: Effective April 1, 2015; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-04-02

45-05-09-04. Acknowledgment.

The applicant or insured must sign a disclosure form as part of the application or renewal process wherein the applicant or insured acknowledges that the subject policy has limits of liability which may be reduced or completely eliminated by payments for legal defense costs ~~and~~ or claims expenses.

History: Effective April 1, 2015.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-04-02

45-05-09-05. Defense-only policies excepted.

Defense-only policies are excepted from the requirements of chapter 45-05-09. A defense-only policy is a policy which is purchased solely to provide a legal defense and is not meant to provide indemnification or to be a source of payment for damages to a third party.

History: Effective April 1, 2015.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-04-02

ARTICLE 45-01
GENERAL ADMINISTRATION

CHAPTER 45-01-01
ORGANIZATION OF DEPARTMENT

45-01-01-01. Organization of insurance department.

1. **History and functions**. Section 12 of article V of the Constitution of North Dakota provides for the office of insurance commissioner. North Dakota Century Code title 26.1 contains statutes pertaining to the commissioner and the department. Besides administering and regulating all matters pertaining to insurance, the commissioner manages the state bonding fund, administers the state fire and tornado fund, administers the petroleum tank release compensation fund, and administers the unsatisfied judgment fund.

2. **Inquiries**. Inquiries regarding the insurance department may be addressed to the commissioner:

   ~~Honorable Adam Hamm~~
   Commissioner
   Insurance Department
   600 East Boulevard Avenue
   Bismarck, North Dakota 58505

History: Amended effective January 1, 1982; August 1, 1983; March 1, 1986; January 1, 1992; February 1, 1993; April 1, 1994; June 1, 2003; January 1, 2009~~.~~; October 1, 2019.
General Authority: NDCC 28-32-02.1
Law Implemented: NDCC 28-32-02.1

CHAPTER 45-06-01.1
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

45-06-01.1-01. Applicability and scope.

1. Except as otherwise specifically provided in sections 45-06-01.1-05, 45-06-01.1-10, 45-06-01.1-11, 45-06-01.1-14, and 45-06-01.1-19, this chapter applies to:

   a. All medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and

   b. All certificates issued under group medicare supplement policies which certificates have been delivered or issued for delivery in this state.

2. This chapter does not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor 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.

History: Effective January 1, 1992; amended effective July 8, 1997.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-02. Definitions.

For purposes of this chapter:

1. "1990 standardized medicare supplement benefit plan", "1990 standardized benefit plan", or "1990 plan" means a group or individual policy of medicare supplement insurance issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010, and includes medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

2. "2010 standardized medicare supplement benefit plan", "2010 standardized benefit plan" or "2010 plan" means a group or individual policy of medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

3. "Applicant" means:

   a. In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

   b. In the case of a group medicare supplement policy, the proposed certificate holder.

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

5. "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

6. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

7. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three days.

8. a. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

      (1) A group health plan;

      (2) Health insurance coverage;

      (3) Part A or part B of title XVIII of the Social Security Act (medicare);

      (4) Title XIX of the Social Security Act other than coverage consisting solely of benefits under section 1928;

      (5) 10 U.S.C. 55 (CHAMPUS);

(6) A medical care program of the Indian health service or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under 5 U.S.C. 89 (federal employees health benefits program);

(9) A public health plan as defined in federal regulations; and

(10) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

b. "Creditable coverage" does not include one or more, or any combination of, the following:

(1) Coverage only for accident or disability income insurance, or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics; and

(8) Other similar insurance coverage, specified in federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

c. "Creditable coverage" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(3) Such other similar, limited benefits as are specified in federal regulations.

d. "Creditable coverage" does not include the following benefits if offered as independent, noncoordinated benefits:

(1) Coverage only for a specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

e. "Creditable coverage" does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplement health insurance as defined under section 1882(g)(1) of the Social Security Act;

(2) Coverage supplemental to the coverage provided under 10 U.S.C. 55; and

(3) Similar supplemental coverage provided to coverage under a group health plan.

9. "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. 1002 (Employee Retirement Income Security Act).

10. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

a. Any capital and surplus required by law for its organization; or

b. The total par or stated value of its authorized and issued capital stock.

11. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

12. "Medicare" means the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

13. "Medicare advantage plan" means a plan of coverage for health benefits under medicare part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

a. Coordinated care plans which provide health care services, including health maintenance organization plans, with or without a point-of-service option; plans offered by provider-sponsored organizations; and preferred provider organization plans;

b. Medical savings account plans coupled with a contribution into a medicare advantage medical savings account; and

c. Medicare advantage private fee-for-service plans.

14. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act [42 U.S.C. 1395 et seq.] or an issued policy under the demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. "Medicare supplement policy" does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D, or any health care prepayment plan that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act.

15. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

16. "Prestandardized medicare supplement benefit plan", "prestandardized benefit plan", or "prestandardized plan" means a group or individual policy of medicare supplement insurance issued prior to January 1, 1992.

17. "Secretary" means the secretary of the United States department of health and human services.

History: Effective January 1, 1992; amended effective August 27, 1998; December 1, 2001;

September 1, 2005; July 1, 2009.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-03. Policy definitions and terms.

No policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

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 which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force".

   b. The definition may provide that injuries do 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", "extended care facility", or "skilled nursing facility" may not be defined more restrictively than as defined in the medicare program.

4. "Health care expenses" means, for purposes of section 45-06-01.1-11, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

5. "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the medicare program.

6. "Medicare" must be defined in the policy and certificate. 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. "Medicare eligible expenses" means expenses of the kinds covered by medicare parts A and B, to the extent recognized as reasonable and medically necessary by medicare.

8. "Physician" may not be defined more restrictively than as defined in the medicare program.

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

History: Effective January 1, 1992; amended effective July 8, 1997; September 1, 2005.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-04. Policy provisions.

1. Except for permitted preexisting condition clauses as described in subdivision a of subsection 1 of section 45-06-01.1-05, subdivision a of subsection 1 of section 45-06-01.1-06, and subdivision a of subsection 1 of section 45-06-01.1-06.1, no policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if the 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. No medicare supplement policy or certificate in force in the state may contain benefits which duplicate benefits provided by medicare.

4. a. Subject to subdivisions d, e, and g of subsection 1 of section 45-06-01.1-05 and subdivisions d and e of subsection 1 of section 45-06-01.1-06, a medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in part D at the option of the policyholder.

   b. A medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

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

      (1) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a medicare part D plan; and

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

History: Effective January 1, 1992; amended effective July 8, 1997; September 1, 2005; July 1, 2009.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-05. Minimum benefit standards for prestandardized medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992.

No policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

1. **General standards.** The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

   b. A medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

   c. 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, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

   d. A "noncancelable", "guaranteed renewable", or "noncancelable and guaranteed renewable" medicare supplement policy may not:

      (1) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

      (2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

   e. (1) Except as authorized by the commissioner of this state, an issuer may neither cancel nor nonrenew a medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

      (2) If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph 4, the issuer must offer certificate holders an individual medicare supplement policy. The issuer must offer the certificate holder at least the following choices:

         (a) An individual medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group medicare supplement policy; and

         (b) An individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection 2 of section 45-06-01.1-06.1.

      (3) If membership in a group is terminated, the issuer must:

         (a) Offer the certificate holder the conversion opportunities described in paragraph 2; or

         (b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

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

f. 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 predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

g. If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

2. **Minimum benefit standards.**

a. Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

b. Coverage for either all or none of the medicare part A inpatient hospital deductible amount.

c. Coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days.

d. Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five days.

e. Coverage under medicare part A 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 or already paid for under part B.

f. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment 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 (one hundred dollars).

g. Effective January 1, 1990, coverage under medicare part 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 or already paid for under part A, subject to the medicare deductible amount.

History: Effective January 1, 1992; amended effective July 1, 1994; April 1, 1996; July 8, 1997; September 1, 2005; July 1, 2009.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03

Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-06. Benefit standards for 1990 standardized medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010.

The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards:

1. **General standards.** The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

   b. A medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

   c. 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, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

   d. 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.

   e. Each medicare supplement policy must be guaranteed renewable:

      (1) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual.

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

      (3) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5, the issuer must offer certificate holders an individual medicare supplement policy which at the option of the certificate holder:

         (a) Provides for continuation of the benefits contained in the group policy; or

         (b) Provides for benefits that otherwise meet the requirements of this subsection.

      (4) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must:

         (a) Offer the certificate holder the conversion opportunity described in paragraph 3; or

(b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

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

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

f. Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

g. (1) 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 certificate holder for the period, not to exceed twenty-four months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396, et seq.], but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medical assistance eligibility, subject to adjustment for paid claims.

(2) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted, effective as of the date of loss of such coverage, if the policyholder provides notice of loss of coverage within ninety days after the date of such loss and pays the premium due from that date.

(4) Reinstitution of coverage as described in paragraphs 2 and 3:

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

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

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

h. If an issuer makes a written offer to the medicare supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from the 1990 standardized plan as described in section 45-06-01.1-07 to a 2010 standardized plan as described in section 45-06-01.1-07.1, the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the commissioner if the insured replaces a 1990 standardized policy or certificate with an issue age rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner.

(2) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(3) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy.

(4) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

2. **Standards for basic core benefits common to benefit plans A through J.** Every issuer must make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it:

a. Coverage of part A medicare-eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

b. Coverage of part A medicare-eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

c. Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance.

d. 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.

e. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare-eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

3. **Standards for additional benefits.** The following additional benefits must be included in medicare supplement benefit plans "B" through "J" only as provided by section 45-06-01.1-07:

a. Medicare part A deductible: Coverage for all of the medicare part A inpatient hospital deductible amount per benefit period.

b. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

c. Medicare part B deductible: Coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the medicare part B excess charges: Coverage for eighty percent 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.

e. One hundred percent of the medicare part B excess charges: Coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

f. Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

g. Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may be included for sale or issuance in a medicare supplement policy until January 1, 2006.

h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. (1) Preventive medical care benefit: Coverage for the following preventive health services not covered by medicare:

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

(b) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(2) Reimbursement must be for the actual charges up to one hundred percent 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

codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by medicare.

j. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

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

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

(b) "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 twenty-four-hour period of services provided by a care provider is one visit.

(c) "Care provider" means a duly qualified or licensed home health aide or 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.

(d) "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 may not be considered the insured's place of residence.

(2) Coverage requirements and limitations.

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

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

(c) Coverage is limited to:

[1] 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 may not exceed the number of medicare-approved home health care visits under a medicare-approved home care plan of treatment.

[2] The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

[3] One thousand six hundred dollars per calendar year.

[4] Seven visits in any one week.

[5] Care furnished on a visiting basis in the insured's home.

[6] Services provided by a care provider as defined in this section.

[7] At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

[8] 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.

(3) Coverage is excluded for:

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

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

4. **Standards for plans K and L.**

a. Standardized medicare supplement benefit plan K shall consist of the following:

(1) Coverage of one hundred percent of the part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

(2) Coverage of one hundred percent of the part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;

(3) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system

rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Medicare part A deductible: Coverage for fifty percent of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph 10;

(5) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A until the out-of-pocket limitation is met as described in paragraph 10;

(6) Hospice care: Coverage for fifty percent of cost-sharing for all part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph 10;

(7) Coverage for fifty percent, under medicare part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in paragraph 10;

(8) Except for coverage provided in paragraph 9, coverage for fifty percent of the cost-sharing otherwise applicable under medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in paragraph 10;

(9) Coverage of one hundred percent of the cost-sharing for medicare part B preventive services after the policyholder pays the part B deductible; and

(10) Coverage of one hundred percent of all cost-sharing under medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States department of health and human services.

b. Standardized medicare supplement benefit plan L shall consist of the following:

(1) The benefits described in paragraphs 1, 2, 3, and 9 of subdivision a;

(2) The benefits described in paragraphs 4, 5, 6, 7, and 8 of subdivision a, but substituting seventy-five percent for fifty percent; and

(3) The benefits described in paragraph 10 of subdivision a, but substituting two thousand dollars for four thousand dollars.

History: Effective January 1, 1992; amended effective April 1, 1996; July 8, 1997; August 1, 2000; December 1, 2001; September 1, 2005; July 1, 2009.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-06.1. Benefit standards for 2010 standardized medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010.

The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of sections 45-06.01.1-06 and 45-06-01.1-07. ~~North Dakota Century Code chapter 26.1-36.1.~~

1. General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this chapter:

   a. A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

   b. A medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

   c. A medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

   d. No medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

   e. Each medicare supplement policy shall be guaranteed renewable.

      (1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

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

      (3) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5, the issuer shall offer certificate holders an individual medicare supplement policy which at the option of the certificate holder:

         (a) Provides for continuation of the benefits contained in the group policy; or

         (b) Provides for benefits that otherwise meet the requirements of this subsection.

      (4) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group the issuer shall:

         (a) Offer the certificate holder the conversion opportunity described in paragraph 3; or

(b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

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

f. Termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

g. (1) A medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medical assistance eligibility subject to adjustment for paid claims.

(2) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate

holder provides notice of loss of entitlement within ninety days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(4) Reinstitution of coverages as described in paragraphs 2 and 3:

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

(b) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

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

2. Standards for basic benefits common to medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N. Every issuer of medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic core package but not in lieu of it.

   a. Coverage of part A medicare-eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period;

   b. Coverage of part A medicare-eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;

   c. Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days coverage of one hundred percent of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

   d. 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, unless replaced in accordance with federal regulations;

   e. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of medicare-eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible; and

   f. Hospice care. Coverage of cost-sharing for all part A medicare eligible hospice care and respite care expenses.

3. Standards for additional benefits. The following additional benefits shall be included in medicare supplement benefit plans B, C, D, F, F with high deductible, G, M, and N as provided by section 45-06-01.1-07.1.

   a. Medicare part A deductible. Coverage for one hundred percent of the medicare part A inpatient hospital deductible amount per benefit period.

   b. Medicare part A deductible. Coverage for fifty percent of the medicare part A inpatient hospital deductible amount per benefit period.

   c. Skilled nursing facility care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

   d. Medicare part B deductible. Coverage for one hundred percent of the medicare part B deductible amount per calendar year regardless of hospital confinement.

e. One hundred percent of the medicare part B excess charges. Coverage for all 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.

f. Medically necessary emergency care in a foreign country. Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

History: Effective July 1, 2009.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-07. Standard medicare supplement benefit plans for 1990 standardized medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010.

1. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsection 2 of section 45-06-01.1-06.

2. No groups, packages, or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in subsection 7 of this section and in section 45-06-01.1-08.

3. Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through " L" listed in this section and conform to the definitions in section 45-06-01.1-02 and contained in North Dakota Century Code section 26.1-36.1-01. Each benefit must be structured in accordance with the format provided in subsections 2 and 3 or 4 of section 45-06-01.1-06 and list the benefits in the order shown in this section. 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 subsection 3, other designations to the extent permitted by law.

5. Makeup of benefit plans:

a. Standardized medicare supplement benefit plan "A" is limited to the basic (core) benefits common to all benefit plans, as defined in subsection 2 of section 45-06-01.1-06.

b. Standardized medicare supplement benefit plan "B" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible as defined in subdivision a of subsection 3 of section 45-06-01.1-06.

c. Standardized medicare supplement benefit plan "C" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible and medically

necessary emergency care in a foreign country as defined in subdivisions a, b, c, and h of subsection 3 of section 45-06-01.1-06, respectively.

d. Standardized medicare supplement benefit plan "D" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in subdivisions a, b, h, and j of subsection 3 of section 45-06-01.1-06, respectively.

e. Standardized medicare supplement benefit plan "E" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, 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 subdivisions a, b, h, and i of subsection 3 of section 45-06-01.1-06, respectively.

f. Standardized medicare supplement benefit plan "F" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, the skilled nursing facility care, the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, b, c, e, and h of subsection 3 of section 45-06-01.1-06, respectively.

g. Standardized medicare supplement benefit high deductible plan "F" includes only the following: one hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, b, c, e, and h of subsection 3 of section 45-06-01.1-06, respectively. The annual high deductible plan "F" deductible consists of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "F" policy, and are in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is one thousand five hundred dollars for 1998 and 1999 and must be based on the calendar year. It must be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year and rounded to the nearest multiple of ten dollars.

h. Standardized medicare supplement benefit plan "G" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, eighty percent of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in subdivisions a, b, d, h, and j of subsection 3 of section 45-06-01.1-06, respectively.

i. Standardized medicare supplement benefit plan "H" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in subdivisions a, b, f, and h of subsection 3 of section 45-06-01.1-06, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

j. Standardized medicare supplement benefit plan "I" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare

part A deductible, skilled nursing facility care, one hundred percent 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 defined in subdivisions a, b, e, f, h, and j of subsection 3 of section 45-06-01.1-06, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

k. Standardized medicare supplement benefit plan "J" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, one hundred percent 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 defined in subdivisions a, b, c, e, g, h, i, and j of subsection 3 of section 45-06-01.1-06, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

l. Standardized medicare supplement benefit high deductible plan "J" consists of only the following: one hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, one hundred percent of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in subdivisions a, b, c, e, g, h, i, and j of subsection 3 of section 45-06-01.1-06, respectively. The annual high deductible plan "J" deductible consists of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "J" policy, and are in addition to any other specific benefit deductibles. The annual deductible is one thousand five hundred dollars for 1998 and 1999 and must be based on a calendar year. It must be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

6. Makeup of two medicare supplement plans mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003:

a. Standardized medicare supplement benefit plan "K" shall consist of only those benefits described in subdivision a of subsection 4 of section 45-06-01.1-06.

b. Standardized medicare supplement benefit plan "L" shall consist of only those benefits described in subdivision b of subsection 4 of section 45-06-01.1-06.

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

History: Effective January 1, 1992; amended effective July 1, 1994; August 27, 1998; September 1,
2005; July 1, 2009.

General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-07.1. Standard medicare supplement benefit plans for 2010 standardized medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010.

The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of section(s) 45-06-01.1-06 and 45-06-01.1-07.~~North Dakota Century Code chapter 26.1-36.1.~~

1. a. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic benefits, as defined in subsection 2 of section 45-06-01.1-06.1.

   b. If an issuer makes available any of the additional benefits described in subsection 3 of section 45-06-01.1-06.1, or offers standardized benefit plans K or L as described in subdivisions h and i of subsection 5, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic benefits as described in subdivision a, a policy form or certificate form containing either standardized benefit plan C as described in subdivision c of subsection 5 or standardized benefit plan F as described in subdivision e of subsection 5.

2. No groups, packages, or combinations of medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subsection 6 and section 45-06-01.1-08.

3. Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in this subsection and conform to the definitions in section 45-06-01.1-02. Each benefit shall be structured in accordance with the format provided in subsections 2 and 3 of section 45-06-01.1-06.1; or, in the case of plans K or L, in subdivisions h and i of subsection 5 and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

4. In addition to the benefit plan designations required in subsection 3, an issuer may use other designations to the extent permitted by law.

5. Makeup of 2010 standardized benefit plans:

   a. Standardized medicare supplement benefit plan A shall include only the following: the basic benefits as defined in subsection 2 of section 45-06-01.1-06.1.

   b. Standardized medicare supplement benefit plan B shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible as defined in subdivision a of subsection 3 of section 45-06-01.1-06.1.

   c. Standardized medicare supplement benefit plan C shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one

hundred percent of the medicare part A deductible, skilled nursing facility care, one hundred percent of the medicare part B deductible, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

d. Standardized medicare supplement benefit plan D shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

e. Standardized medicare supplement plan F shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, the skilled nursing facility care, one hundred percent of the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

f. Standardized medicare supplement plan F with high deductible shall include only the following: one hundred percent of covered expenses following the payment of the annual deductible set forth in paragraph 2.

(1) The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, one hundred percent of the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

(2) The annual deductible in plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars and shall be adjusted annually from 1999 by the secretary of the United States department of health and human services to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

g. Standardized medicare supplement benefit plan G shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, one hundred

percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively. Effective January 1, 2020, the standardized benefit plans described in subdivision d of subsection 1 of section 45-06-01.1-07.2 of this regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

h. Standardized medicare supplement plan K is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall include only the following:

(1) Part A hospital coinsurance, sixty-first through ninetieth days. Coverage of one hundred percent of the part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

(2) Part A hospital coinsurance, ninety-first through one hundred fiftieth days. Coverage of one hundred percent of the part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;

(3) Part A hospitalization after one hundred fifty days. Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Medicare part A deductible. Coverage for fifty percent of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph 10;

(5) Skilled nursing facility care. Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A until the out-of-pocket limitation is met as described in paragraph 10;

(6) Hospice care. Coverage for fifty percent of cost-sharing for all part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph 10;

(7) Blood. Coverage for fifty percent, under medicare part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in paragraph 10;

(8) Part B cost-sharing. Except for coverage provided in paragraph 9, coverage for fifty percent of the cost-sharing otherwise applicable under medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in paragraph 10;

(9) Part B preventive services. Coverage of one hundred percent of the cost-sharing for medicare part B preventive services after the policyholder pays the part B deductible; and

(10) Cost-sharing after out-of-pocket limits. Coverage of one hundred percent of all cost-sharing under medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States department of health and human services.

i. Standardized medicare supplement plan L is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall include only the following:

(1) The benefits described in paragraphs 1, 2, 3, and 9 of subdivision h of subsection 5 of section 45-06-01.1-07.1;

(2) The benefit described in paragraphs 4, 5, 6, 7, and 8 of subdivision h of subsection 5 of section 45-06-01.1-07.1, but substituting seventy-five percent for fifty percent; and

(3) The benefit described in paragraph 10 of subdivision h of subsection 5 of section 45-06-01.1-07.1, but substituting two thousand dollars for four thousand dollars.

j. Standardized medicare supplement plan M shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus fifty percent of the medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subdivisions b, c, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

k. Standardized medicare supplement plan N shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, and f of subsection 3 of section 45-06-01.1-06.1, respectively, with copayments in the following amounts:

(1) The lesser of twenty dollars or the medicare part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and

(2) The lesser of fifty dollars or the medicare part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a medicare part A expense.

6. New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

History: Effective July 1, 2009.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-07.2. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for Delivery to individuals Newly Eligible for Medicare on or After January, 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1,

2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of sections 45-06-01.1-06, 45-06-01.1-06.1, 45-06-01.1-07, and 45-06-01.1-07.1.

1. Benefit Requirements. The standards and requirements of section 45-06-01.1-07.1 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

    a. Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in subdivision c of subsection 5 of section 45-06-01.1-07.1 of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

    b. Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in subdivision e of subsection 5 of section 45-06-01.1-07.1 of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

    c. Standardized Medicare supplement benefit places C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

    d. Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in subdivision f of subsection 5 of section 45-06-01.1-07.1 of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

    e. The reference to Plans C or F contained in subdivision b of subsection 1 of section 45-06-01.1-07.1 is deemed a reference to Plans D or G for purposes of this section.

2. Applicability to Certain Individuals. This section applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

    a. By reason of attaining age 65 on or after January 1, 2020; or

    b. By reason of entitlement to benefits under part A pursuant to Section 226 (b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

3. Guaranteed Issue for Eligible Persons. For purposes of subsection 5 of section 45-06-01.1-09.1 in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of subsection 1.

4. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

5. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in subdivision d of subsection 1, above may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in subsection 5 of section 45-06-01.1-07.1 of this regulation.

History: Effective January 1, 2020.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-08. Medicare select policies and certificates.

1. a. This section applies to medicare select policies and certificates, as defined in this section.

   b. No policy or certificate may be advertised as a medicare select policy or certificate unless it meets the requirements of this section.

2. For the purposes of this section:

   a. "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select issuer or its network providers.

   b. "Grievance" means dissatisfaction expressed in writing by an individual insured under a medicare select policy or certificate with the administration, claims practices, or provision of services concerning a medicare select issuer or its network providers.

   c. "Medicare select issuer" means an issuer offering, or seeking to offer, a medicare select policy or certificate.

   d. "Medicare select policy" or "medicare select certificate" mean respectively a medicare supplement policy or certificate that contains restricted network provisions.

   e. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a medicare select policy.

   f. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

   g. "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a medicare select policy.

3. The commissioner may authorize an issuer to offer a medicare select policy or certificate, pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101-508; 104 Stat. 1388; 42 U.S.C. 1395ss(t)(1)] if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

4. A medicare select issuer may not issue a medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

5. A medicare select issuer must file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation must contain at least the following information:

   a. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

      (1) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care must reflect usual practice in the local area. Geographic availability must reflect the usual travel times within the community.

      (2) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

         (a) To deliver adequately all services that are subject to a restricted network provision; or

         (b) To make appropriate referrals.

      (3) There are written agreements with network providers describing specific responsibilities.

      (4) Emergency care is available twenty-four hours per day and seven days per week.

      (5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate. This paragraph does not apply to supplemental charges or coinsurance amounts as stated in the medicare select policy or certificate.

   b. A statement or map providing a clear description of the service area.

   c. A description of the grievance procedure to be utilized.

   d. A description of the quality assurance program, including:

      (1) The formal organizational structure;

      (2) The written criteria for selection, retention, and removal of network providers; and

      (3) The procedures for evaluating quality of care provided by network providers and the process to initiate corrective action when warranted.

   e. A list and description, by specialty, of the network providers.

   f. Copies of the written information proposed to be used by the issuer to comply with subsection 9.

   g. Any other information requested by the commissioner.

6. a. A medicare select issuer must file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to

implementing such changes. Such changes must be considered approved by the commissioner after thirty days unless specifically disapproved.

b. An updated list of network providers must be filed with the commissioner at least quarterly.

7. A medicare select policy or certificate may not restrict payment for covered services provided by non-network providers if:

   a. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

   b. It is not reasonable to obtain such services through a network provider.

8. A medicare select policy or certificate must provide payment for full coverage under the policy for covered services that are not available through network providers.

9. A medicare select issuer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure must include at least the following:

   a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with:

      (1) Other medicare supplement policies or certificates offered by the issuer; and

      (2) Other medicare select policies or certificates.

   b. A description (including address, telephone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

   c. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

   d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

   e. A description of limitations on referrals to restricted network providers and to other providers.

   f. A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the issuer.

   g. A description of the medicare select issuer's quality assurance program and grievance procedure.

10. Prior to the sale of a medicare select policy or certificate, a medicare select issuer must obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection 9 and that the applicant understands the restrictions of the medicare select policy or certificate.

11. A medicare select issuer must have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures must be aimed at mutual agreement for settlement and may include arbitration procedures.

a. The grievance procedure must be described in the policy and certificates and in the outline of coverage.

b. At the time the policy or certificate is issued, the issuer must provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

c. Grievances must be considered in a timely manner and shall be transmitted to appropriate decisionmakers who have authority to fully investigate the issue and take corrective action.

d. If a grievance is found to be valid, corrective action must be taken promptly.

e. All concerned parties must be notified about the results of a grievance.

f. The issuer must report no later than each March thirty-first to the commissioner regarding its grievance procedure. The report must be in a format prescribed by the commissioner and must contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

12. At the time of initial purchase, a medicare select issuer must make available to each applicant for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the issuer.

13. a. At the request of an individual insured under a medicare select policy or certificate, a medicare select issuer must make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the issuer which has

comparable or lesser benefits and which does not contain a restricted network provision. The issuer must make the policies or certificates available without requiring evidence of insurability after the medicare select policy or certificate has been in force for six months.

b. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery services, or coverage for medicare part B excess charges.

14. Medicare select policies and certificates must provide for continuation of coverage in the event the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment.

a. Each medicare select issuer must make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer must make such policies and certificates available without requiring evidence of insurability.

b. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one

or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery services, or coverage for part B excess charges.

15. A medicare select issuer must comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purpose of evaluating the medicare select program.

History: Effective January 1, 1992; amended effective July 8, 1997; September 1, 2005.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-09. Open enrollment.

1. Any issuer may not deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, or 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 in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both sixty-five years of age or older and is 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. a. If an applicant qualifies under subsection 1 and submits an application during the time period referenced in subsection 1 and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer may not exclude benefits based on a preexisting condition.

   b. If the applicant qualifies under subsection 1 and submits an application during the time period referenced in subsection 1 and, as of the date of application, has had a

   continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

3. Except as provided in subsection 2 and sections 45-06-01.1-09.1 and 45-06-01.1-20, subsection 1 may 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 certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

History: Effective January 1, 1992; amended effective July 8, 1997; August 27, 1998; September 1,
2005.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-09.1. Guaranteed issue for eligible persons.

1. **Guaranteed issue.**

   a. Eligible persons are those individuals described in subsection 2 who seek to enroll under the policy during the period specified in subsection 3, and who submit

evidence of the date of termination, disenrollment, or medicare part D enrollment with the application for a medicare supplement policy.

b. With respect to eligible persons, an issuer may not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsection 5 that is offered and is available for issuance to new enrollees by the issuer, may not discriminate in the pricing of such a medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and may not impose an exclusion of benefits based on a preexisting condition under such a medicare supplement policy.

2. **Eligible persons.** An eligible person is an individual described in any of the following subdivisions:

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

b. The individual is enrolled with a medicare advantage organization under a medicare advantage plan under part C of medicare, and any of the following circumstances apply, or the individual is sixty-five years of age or older and is enrolled with a program of all-inclusive care for the elderly provider under section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a medicare advantage plan:

(1) The organization's or plan's certification has been terminated;

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(3) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, if the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856, or the plan is terminated for all individuals within a residence area;

(4) The individual demonstrates, in accordance with guidelines established by the secretary, that:

(a) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(b) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provision in marketing the plan to the individual; or

(5) The individual meets such other exceptional conditions as the secretary may provide.

c. (1) The individual is enrolled with:

(a) An eligible organization operating under a contract under section 1876 of the Social Security Act (medicare cost);

(b) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(c) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(d) An organization under a medicare select policy; and

(2) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision b of subsection 2;

d. The individual is enrolled under a medicare supplement policy and the enrollment ceases because:

(1) (a) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(b) Of other involuntary termination of coverage or enrollment under the policy;

(2) The issuer of the policy substantially violated a material provision of the policy; or

(3) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

e. (1) The individual was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any medicare advantage organization under a medicare advantage plan under part C of medicare, any eligible organization under a contract under section 1876 of the Social Security Act regarding medicare cost, any similar organization operating under demonstration project authority, any program of all-inclusive care for the elderly provider under section 1894 of the Social Security Act, or a medicare select policy; and

(2) The subsequent enrollment under paragraph 1 is terminated by the enrollee during any period within the first twelve months of such subsequent enrollment, during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act; or

f. The individual, upon first becoming eligible for benefits under part A of medicare at age sixty-five, enrolls in a medicare advantage plan under part C of medicare, or in a program of all-inclusive care for the elderly provider under section 1894 of the Social

Security Act, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.

g. The individual enrolls in a medicare part D plan during the initial enrollment period and, at the time of enrollment in part D, was enrolled under a medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare part D along with the application for a policy described in subdivision d of subsection 5.

3. **Guaranteed issue time periods.**

a. In the case of an individual described in subdivision a of subsection 2, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if such notice is not received, notice that a claim has been denied because of a termination or cessation; or
(ii) the date that the applicable coverage terminates or ceases; and ends sixty-three days thereafter;

b. In the case of an individual described in subdivision b, c, e, or f of subsection 2 whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date the applicable coverage is terminated;

c. In the case of an individual described in paragraph 1 of subdivision d of subsection 2, the guaranteed issue period begins on the earlier of (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated;

d. In the case of an individual described in subdivision b, d, e, or f of subsection 2 who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends sixty-three days after the effective date;

e. In the case of an individual described in subdivision g of subsection 2, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v) (2)(B) of the Social Security Act from the medicare supplement issuer during the sixty-day period immediately preceding the initial part D enrollment period and ends on the date that is sixty-three days after the effective date of the individual's coverage under medicare part D; and

f. In the case of an individual described in subsection 2 but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three days after the effective date.

4. **Extended medigap access for interrupted trial periods.**

a. In the case of an individual described in subdivision e of subsection 2, or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or

provider described in paragraph 1 of subdivision e of subsection 2 is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision e of subsection 2;

b. In the case of an individual described in subdivision f of subsection 2, or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in subdivision f of subsection 2 is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subdivision f of subsection 2; and

c. For purposes of subdivisions e and f of subsection 2, no enrollment of an individual with an organization or provider described in paragraph 1 of subdivision e of subsection 2, or with a plan or in a program described in subdivision f of subsection 2, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

5. **Products to which eligible persons are entitled.** The medicare supplement policy to which eligible persons are entitled under:

a. Subdivisions a, b, c, and d of subsection 2 are a medicare supplement policy that has a benefit package classified as plan A, B, C, F (including F with a high deductible), K, or L offered by any issuer.

b. (1) Subject to paragraph 2, subdivision e of subsection 2 is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in subdivision a.

(2) After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this paragraph is:

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

(b) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K, or L policy that is offered by any issuer.

c. Subdivision f of subsection 2 includes any medicare supplement policy offered by any issuer.

d. Subdivision g of subsection 2 is a medicare supplement policy that has a benefit package classified as plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's medicare supplement policy with outpatient prescription drug coverage.

6. **Notification provisions.**

a. At the time of an event described in subsection 2 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify

the individual of the individual's rights under this section, and of the obligations of the issuers of

medicare supplement policies under subsection 1. Such notice shall be communicated contemporaneously with the notification of termination.

b. At the time of an event described in subsection 2 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this section, and of the obligations of issuers of medicare supplement policies under subsection 1. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

History: Effective August 27, 1998; amended effective December 1, 2001; September 1, 2005; July 1,
2009.
General Authority: NDCC 26.1-36.1-02, 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-10. Standards for claims payment.

1. An issuer must comply with 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 (Pub. L. 100-203; 101 Stat. 1330; 42 U.S.C. 1395ss(c)(3))] by:

   a. Accepting a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in 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 requirements set forth in subsection 1 must be certified on the medicare supplement insurance experience reporting form.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-11. Loss ratio standards and refund or credit of premium.

1. **Loss ratio standards.**

a. (1) A medicare supplement policy form or certificate form may not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not

including anticipated refunds or credits) provided under the policy form or certificate form:

(a) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; or

(b) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies;

(2) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses when coverage is provided by a health maintenance organization 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; and

(g) Claims processing costs.

b. All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this section 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.

c. For purposes of applying subdivision a of subsection 1 of this section and subdivision c of subsection 4 of section 45-06-01.1-12 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are deemed to be group policies.

d. For policies issued prior to January 1, 1992, expected claims in relation to premiums must meet:

(1) The originally filed anticipated loss ratios when combined with the actual experience since inception;

(2) The appropriate loss ratio requirements from subparagraphs a and b of paragraph 1 of subdivision a when combined with actual experience beginning with July 1, 1997, to date; and

(3) The appropriate loss ratio requirement from subparagraphs a and b of paragraph 1 of subdivision a over the entire future period for which the rates are computed to provide coverage.

2. **Refund or credit calculation.**

a. An issuer must collect and file with the commissioner by May thirty-first of each year the data contained in the applicable reporting form contained in appendix A for each type in a standard medicare supplement benefit plan.

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation 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 must be excluded.

c. For the purposes of this section, policies or certificates issued prior to January 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1997. The first report is due by May 31, 1998.

d. A refund or credit may 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. The refund must 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 may it be less than the average rate of interest for thirteen-week treasury notes. A refund or credit against premiums due must be made by September thirtieth following the experience year upon which the refund or credit is based.

3. **Annual filing of premium rates.** An issuer of medicare supplement policies and certificates issued before or after the effective date of this chapter 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. 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. The demonstration must exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage must be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in medicare benefits, every issuer of medicare supplement policies or certificates in this state must file with the commissioner, in accordance with the applicable filing procedures of this state:

a. (1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents as necessary to justify the adjustment must accompany the filing.

(2) An issuer must make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for medicare supplement policies and which are expected to result

in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein may be made with respect to a policy at any time other than upon its renewal date or anniversary date.

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

b. Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with medicare. The riders, endorsements, or policy forms must provide a clear description of the medicare supplement benefits provided by the policy or certificate.

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

History: Effective January 1, 1992; amended effective July 8, 1997; September 1, 2005.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-04

45-06-01.1-12. Filing and approval of policies and certificates and premium rates.

1. An issuer may not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

2. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug Improvement and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

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

4. a. Except as provided in subdivision b of this subsection, an issuer may not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

b. 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:

(1) The inclusion of new or innovative benefits.

(2) The addition of either direct response or agent marketing methods.

(3) The addition of either guaranteed issue or underwritten coverage.

(4) The offering of coverage to individuals eligible for medicare by reason of disability.

c. For the purposes of this section, a "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

5. a. Except as provided in paragraph 1, an issuer must continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form

may not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(1) 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 may no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph 1 may not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

b. The sale or other transfer of medicare supplement business to another issuer is considered a discontinuance for the purposes of this subsection.

c. A change in the rating structure or methodology is considered a discontinuance under subdivision a unless the issuer complies with the following requirements:

(1) 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 existing rates.

(2) 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.

6. a. Except as provided in subdivision b, 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 section 45-06-01.1-11.

b. Forms assumed under an assumption reinsurance agreement may not be combined with the experience of other forms for purposes of the refund or credit calculation.

History: Effective January 1, 1992; amended effective July 1, 1994; September 1, 2005.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-13. Permitted compensation arrangements.

1. An issuer or other entity must provide level commissions or other compensation to an agent or other representative for the sale of a medicare supplement policy or certificate for the year of issuance and no fewer than five renewal years.

2. No issuer or other entity may provide compensation to its agents or other producers and no agent or producer may receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

3. For purposes of this section, "compensation" includes pecuniary or nonpecuniary 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.

4. This section does not apply to an issuer or other entity that provides a one-time commission or other compensation provided the amount paid to an agent or other representative for the sale of a medicare supplement insurance policy or certificate does not exceed twenty-five dollars. This payment is in lieu of level commissions.

History: Effective January 1, 1992; amended effective January 6, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2)
Law Implemented: NDCC 26.1-36.1-03

45-06-01.1-14. Required disclosure provisions.

1. **General rules.**

   a. Medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract issued. Such provision must be appropriately captioned and must appear on the first page of the policy, 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.

   b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, 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 which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement policies, or if the increased benefits or coverage is required by law. When 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.

c. Medicare supplement policies or certificates may not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

d. If a medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "preexisting condition limitations".

e. Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder has the right to return the policy or certificate within thirty 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.

f. (1) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for medicare must provide to those applicants a guide to health insurance for people with medicare in the form developed jointly by the national association of insurance commissioners and the centers for medicare and medicaid services and in a type size no smaller than twelve-point type. Delivery of the guide must be made whether or not such policies or certificates are advertised, solicited, or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the guide must be made to the

applicant at the time of application and acknowledgment of receipt of the guide must be obtained by the insurer. Direct response issuers must deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

(2) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

2. **Notice requirements.**

a. As soon as practicable, but no later than thirty days prior to the annual effective date of any medicare benefit changes, an issuer must notify its policyholders and certificate holders of modifications it has made to medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice must:

(1) Include a description of revisions to the medicare program and a description of each modification made to the coverage provided under the medicare supplement policy or certificate; and

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in medicare.

b. The notice of benefit modifications and any premium adjustments must be in outline form and in clear and simple terms so as to facilitate comprehension.

c. Such notices may not contain or be accompanied by any solicitation.

3. **Medicare Prescription Drug Improvement and Modernization Act of 2003 notice requirements.** Issuers must comply with any notice requirements of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

4. **Outline of coverage requirements for medicare supplement policies.**

a. Issuers must provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, must obtain an acknowledgment of receipt of the outline from the applicant; and

b. 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 twelve-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."

c. The outline of coverage provided to applicants pursuant to this section 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 twelve-point type. All plans must be shown on the cover page, and the plans that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

d. The following items must be included in the outline of coverage in the order prescribed below:

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

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

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

Basic Benefits:

- **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** - Part B coinsurance (generally 20 percent of Medicare- approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** - First three pints of blood each year.
- **Hospice** - Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year ~~[$2,000]~~ [$2,240] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed ~~[$2,000]~~ [$2,240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.	Out-of-pocket limit ~~[$4,620]~~ [$5,240]; paid at 100% after limit reached	Out-of-pocket limit ~~[$2,310]~~ [$2,620]; paid at 100% after limit reached		

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

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

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be

shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to subsection 4 of Section 45-06-01.1-07.1.]

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

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' first eligible for Medicare before 2020 may purchase plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefits is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment					50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance					50%	75%	✓	✓	✓	✓
Medicare Part A deductible					50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2018][2]					[$5240][2]	[$2620][2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of ~~[$2200]~~ [$2,240] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$1,068]~~ [$1,340]	$0	~~[$1,068]~~ [$1,340] (Part A deductible)
61st thru 90th day	All but ~~[$267]~~ [$335] a day	~~[$267]~~ [$335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~[$534]~~ [$670] a day	~~[267]~~ [$670] a day	$0
--Once lifetime reserve days are used:			$0**
--Additional 365 days	$0	100% of Medicare-eligible expenses	All costs
--Beyond the additional 365 days	$0	$0	
SKILLED NURSING FACILITY CARE*		$0	$0
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		
21st thru 100th day	All but ~~[$164.50]~~[$167.50] a day	$0	Up to ~~[$164.50]~~[$167.50] a day
101st day and after	$0	$0	All costs
BLOOD	$0	3 pints	$0
First 3 pints			
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			

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

PLAN A

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

* Once you have been billed ~~[$135]~~[$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First ~~[$135]~~[$183] of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B Excess Charges (Above Medicare-approved	$0 Generally 80% $0	$0 Generally 20% $0	~~[$135]~~[$183] (Part B deductible) $0 All costs
BLOOD First 3 pints Next ~~[$135]~~[$183] of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All costs $0 20%	$0 ~~[$135]~~[$183] (Part B deductible) $0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES --Medically necessary skilled care services and medical supplies --Durable medical equipment	100%	$0	$0
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$1,068]~~[$1,340]	~~[$1,068]~~[$1,340] (Part A deductible)	$0
61st thru 90th day	All but ~~[$267]~~[$335] a day	~~[$267]~~ [$335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~[$534]~~[$670] a day	~~[$534]~~[$670] 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*	All approved amounts	$0	$0
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days			

21st thru 100th day	All but ~~[$133.50]~~[$167.50] a day	$0	Up to ~~[$133.50]~~[$167.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

* Once you have been billed ~~[$135]~~[$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of	80%	20%	$0

Medicare-approved amounts			
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			$0
First 60 days	All but ~~[$1,068]~~[$1,340]	~~[$1,068]~~[$1,340] (Part A deductible)	
61st thru 90th day	All but ~~[$267]~~[$335] a day	~~[$267]~~[$335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~[$534]~~[$670] a day	~~[$534]~~[$670] 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 [~~$133.50~~][$167.50] a day	Up to [~~$133.50~~][$167.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN C

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

* Once you have been billed [~~$135~~][$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [~~$135~~][$183] of Medicare-approved amounts*	$0	[~~$135~~][$183] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next [~~$135~~][$183] of Medicare-approved	$0	[~~$135~~][$183] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES --Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	~~[$135]~~[$183] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$1,068]~~[$1,340]	~~[$1,068]~~[$1,340] (Part A deductible)	$0
61st thru 90th day	All but ~~[$267]~~[$335] a	~~[$267]~~[$335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~[$534]~~[$670] a day	~~[$534]~~[$670] 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 ~~[$133.50]~~[$167.50] a day	Up to ~~[$133.50]~~[$167.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN D

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

* Once you have been billed ~~[$135]~~[$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES--			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE	100%	$0	$0
MEDICARE-APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies			
--Durable medical equipment			
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,240]~~[$2,000]~~ deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2,240]~~[$2,000]~~. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~[$2,000]~~[$2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~[$2,000]~~[$2,240] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$1,068]~~[$1,340]	~~[$1,068]~~[$1,340] (Part A deductible)	$0
61st thru 90th day	All but ~~[$267]~~[$335] a day	~~[$267]~~[$335] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but ~~[$534]~~[$670] a day	~~[$534]~~[$670] a day	
Once lifetime reserve days are used:		100% of	
Additional 365 days	$0	Medicare-eligible expenses	$0
Beyond the additional 365 days	$0	$0	$0***
SKILLED NURSING FACILITY CARE*		$0	$0
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		
21st thru 100th day	All but ~~[$133.50]~~[$167.50] a day	Up to ~~[$133.50]~~[$167.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional

365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

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

* Once you have been billed ~~[$135]~~[$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year ~~[$2,000]~~[$2,240] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~[$2,000]~~[$2,240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~[$2,000]~~[$2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~[$2,000]~~[$2,240] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	~~[$135]~~[$183] (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next ~~[$135]~~[$183] of Medicare-approved amounts*	$0	~~[$135]~~[$183] (Part B deductible)	$0

Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~[$2,000]~~[$2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~[$2,000]~~[$2,240] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	~~[$135]~~[$183] (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY ~~[$2,000]~~[$2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO ~~[$2,000]~~[$2,240] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies	All but [$1,068]	[$1,068] (Part A deductible)	$0
First 60 days	All but [$267] a day	[$267] a day	$0
61st thru 90th day	All but [$534] a day	[$534] a day	$0
91st day and after:	$0	100% of Medicare-eligible expenses	$0**
--While using 60 lifetime reserve days	$0	$0	All costs
--Once lifetime reserve days are used:			
--Additional 365 days			
--Beyond the additional 365 days			
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	All approved amounts	$0	$0
First 20 days			
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

62

PLAN G

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

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

* Once you have been billed [$133.50] 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.

~~PLAN G~~
~~PARTS A & B~~

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

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

~~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	$0	$0	$250
First $250 each calendar year			
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE PLAN G

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

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

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2,240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2,240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,340]	$[1,340] (Part A deductible)	$0
61st thru 90th day	All but $[335] a day	$[335] a day	$0
91st day and after:			
-- While using 60 lifetime reserve days	All but $[670] a day	$[670] a day	$0
-- Once lifetime reserve days are used:			
-- Additional 365 days	$0	100% of Medicare eligible expenses	$0***
-- Beyond the additional 365 days	$0	$0	All costs

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[167.5] a day	Up to $[167.50] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

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

PLAN G or HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2240] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2240]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$183 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont.)

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
BLOOD			
First 3 pints	$0	All costs	$0
Next $[183] of Medicare Approved Amounts*	$0	$0	$183 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $[183] of Medicare Approved Amounts*	$0	$0	$183 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2240] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~[$4,620]~~[$5,240] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$1,068]~~[$1,340]	~~[$534]~~[$670] (50% of Part A deductible)	~~[$534]~~[$670] (50% of Part A deductible)♦
61st thru 90th day	All but ~~[$267]~~[$335] a day	~~[$267]~~[$335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~[$534]~~[$670] a day		
--Once lifetime reserve days are used:		~~[$534]~~[$670] a day	$0
--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 ~~[$133.50]~~[$167.50] a day	Up to ~~[$66.75]~~[$83.75] a day	Up to ~~[$166.75]~~[$183.75] a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

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

PLAN K

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

**** Once you have been billed ~~[$135]~~[$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~[$135]~~[$183] of Medicare-approved amounts****	$0	$0	~~[$135]~~[$183] (Part B deductible)****♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of ~~[$4,620]~~[$5,240])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next ~~[$135]~~[$183] of Medicare-approved amounts****	$0	$0	~~[$135]~~[$183] (Part B deductible)****♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦

CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~[$4,620]~~[$5,240] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First ~~[$135]~~[$183] of Medicare-amounts*****	$0	$0	~~[$135]~~[$183] (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	10%	10%♦

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~[$2,310]~~[$2,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$1,068]~~ [$1,340]	~~[$808.50]~~[$1,005] (75% of Part A deductible)	~~[$267]~~[$335] (25% of Part A deductible)♦
61st thru 90th day	All but ~~[$267]~~[$335] a day	~~[$267]~~[$335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~[$534]~~[$670] a day	~~[$534]~~[$670] 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 ~~$133.50~~[$167.50] a day	Up to ~~[$100.13]~~[$125.63] a day	Up to ~~[$33.38]~~[$41.88] a day♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance♦

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

PLAN L

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

**** Once you have been billed ~~[$135]~~[$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First ~~[$135]~~[$183] of Medicare-approved amounts****	$0	$0	~~[$135]~~[$183] (Part B deductible)****♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of ~~[$2,310]~~[$2,620])*
BLOOD First 3 pints	$0	75%	25%♦
Next ~~[$135]~~[$183] of Medicare-approved amounts****	$0	$0	~~[$135]~~[$183] (Part B deductible)♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦

CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~[$2,560]~~[$2,620] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	$0	$0
--Durable medical equipment			
First ~~[$135]~~[$183] of Medicare-amounts*****	$0	$0	~~[$135]~~[$183] (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	15%	5%♦

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$1,068]~~[$1,340]	~~[534]~~[$670] (50% of Part A deductible)	~~[534]~~[$670] (50% of Part A deductible)
61st thru 90th day	All but ~~[$267]~~[$335] a day	~~[$267]~~[$335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~[$534]~~[$670] a day	~~[$534]~~[$670] 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 ~~[$133.50]~~[$167.50] a day	Up to ~~[$133.50]~~[$167.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN M

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

* Once you have been billed ~~[$135]~~[$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
--Durable medical equipment	100%	$0	$0
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~[$1,068]~~[$1,340]	~~[$1,068]~~[$1,340] (Part A deductible)	$0
61st thru 90th day	All but ~~[$267]~~[$335] a day	~~[$267]~~[$335] a day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but ~~[$534]~~[$670] a day	~~[$534]~~[$670] 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 ~~[$133.50]~~[$167.50] a day	Up to ~~[$133.50]~~[$167.50] 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	0%

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

PLAN N

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

* Once you have been billed ~~[$135]~~[$183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next ~~[$135]~~[$183] of Medicare-approved amounts*	$0	$0	~~[$135]~~[$183] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies			
--Durable medical equipment	100%	$0	$0
First ~~[$135]~~[$183] of Medicare-amounts*	$0	$0	~~[$135]~~[$183] (Part B
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

5. **Notice regarding policies or certificates that are not medicare supplement policies.**

   a. Any accident and sickness insurance policy or certificate, other than a medicare supplement policy; a policy issued pursuant to a contract under section 1876 of the Social Security Act [42 U.S.C. 1395 et seq.]; disability income policy; or other policy identified in subsection 2 of section 45-06-01.1-01, issued for delivery in this state to persons eligible for medicare, must notify insureds under the policy that the policy is not a medicare supplement policy or certificate. The notice must either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice must be in no less than twelve-point type and must contain the following language:

   "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

   b. Applications provided to persons eligible for medicare for the health insurance policies for certificates described in subdivision a must disclose, using the applicable statement in appendix C, the extent to which the policy duplicates medicare. The disclosure statement must be provided as a part of, or together with, the application for the policy or certificate.

History: Effective January 1, 1992; amended effective August 1, 1992; July 1, 1994; April 1, 1996; July 1, 1998; August 27, 1998; December 1, 2001; September 1, 2005; July 1, 2009; January 1, 2020.

General Authority: NDCC 26.1-36.1-03, 26.1-36.1-05
Law Implemented: NDCC 26.1-36.1-05

45-06-01.1-15. Requirements for application forms and replacement coverage.

1. Application forms must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has medicare supplement, medicare advantage, medicaid coverage, or other health insurance 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 agent containing such questions and statements may be used.

[Statements]

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. If, after purchasing this policy, you become eligible for medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state medical assistance program, including benefits as a qualified medicare beneficiary (QMB) and a special low-income medicare beneficiary (SLMB).

[Questions]

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

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

1. a. Did you turn age 65 in the last 6 months?

Yes

No

b. Did you enroll in Medicare Part B in the last 6 months?

Yes

No

c. If yes, what is the effective date?

2. Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes

No

If yes,

a. Will Medicaid pay your premiums for this Medicare supplement policy?

Yes

No

b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes

No

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

START / / END / /

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

Yes

No

c. Was this your first time in this type of Medicare plan?

Yes

No

d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes

No

4. a. Do you have another Medicare supplement policy in force?

Yes

No

b. If so, with what company, and what plan do you have [optional for Direct Mailers]?

c. If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes

No

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes

No

a. If so, with what company and what kind of policy?

b. What are your dates of coverage under the other policy?

START / / END / /

If you are still covered under the other policy, leave "END" blank.

2. Agents shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past 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, must be returned to the applicant by the insurer upon delivery of the policy.

4. Upon determining that a sale will involve replacement of medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, must furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, must be provided to the applicant and an additional signed copy must be retained by the issuer. A direct response issuer must deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement coverage.

5. The notice required by subsection 4 for an issuer must be provided in substantially the following form in no less than twelve-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF

MEDICARE SUPPLEMENT INSURANCE

OR MEDICARE ADVANTAGE

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

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

Additional benefits.

No change in benefits, but lower premiums.

Fewer benefits and lower premiums.

My plan has outpatient prescription drug coverage and I am enrolling in Part D.

Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment [Optional only for Direct Mailers].

Other. (please specify)

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

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

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the 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 Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

6. 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.

History: Effective January 1, 1992; amended effective July 1, 1994; April 1, 1996; July 8, 1997;

September 1, 2005.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02, 26.1-36.1-05

45-06-01.1-16. Filing requirements for advertising.

An issuer must provide a copy of any medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the insurance commissioner of this state for review or approval by the commissioner to the extent it may be required under state law.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-07

45-06-01.1-17. Standards for marketing.

1. An issuer, directly or through its producers, must:

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

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

   c. Display prominently by type, stamp, or other appropriate means on the first page of the policy the following:

      "Notice to buyer: This policy may not cover all of your medical expenses."

   d. 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.

   e. Establish auditable procedures for verifying compliance with this subsection.

2. In addition to the practices prohibited in North Dakota Century Code chapter 26.1-04, 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 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 insurance agent or insurance company.

3. The terms "medicare supplement", "medigap", "medicare wraparound", and words of similar import may not be used unless the policy is issued in compliance with this chapter.

History: Effective January 1, 1992.

General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-18. Appropriateness of recommended purchase and excessive insurance.

1. In recommending the purchase or replacement of any medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

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

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

History: Effective January 1, 1992; amended effective September 1, 2005.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-19. Reporting of multiple policies.

1. On or before March first of each year, an issuer must report the following information for every individual resident of this state for which the issuer has in force more than one medicare supplement policy or certificate:

   a. Policy and certificate number.

   b. Date of issuance.

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

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-20. 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 issuer must waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or certificate for similar benefits to the extent such 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 may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate.

History: Effective January 1, 1992; amended effective September 1, 2005.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-20.1. Prohibition against use of genetic information and requests for genetic testing.

This section applies to all policies with policy years beginning on or after May 21, 2009.

1. An issuer of a medicare supplement policy or certificate shall not:

   a. Deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to such individual; and

   b. Discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to such individual.

2. Nothing in subsection a shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

   a. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

   b. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

3. An issuer of a medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

4. Subsection 3 shall not be construed to preclude an issuer of a medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with subsection 1.

5. For purposes of carrying out subsection 4, an issuer of a medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

6. Notwithstanding subsection 3, an issuer of a medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

   a. The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

   b. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

      (1) Compliance with the request is voluntary; and

      (2) Noncompliance will have no effect on enrollment status or premium or contribution amounts.

   c. No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

d. The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

e. The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

7. An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

8. An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

9. If an issuer of a medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subsection 8 if such request, requirement, or purchase is not in violation of subsection 7.

10. For the purposes of this section only:

a. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

b. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

c. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

d. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

e. "Issuer of a medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

f. "Underwriting purposes" means:

(1) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(2) The computation of premium or contribution amounts under the policy;

(3) The application of any preexisting condition exclusion under the policy; and

(4) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

History: Effective July 1, 2009.
General Authority: NDCC 26.1-36.1-02(1)(20), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-21. Separability.

If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances may not be affected thereby.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

~~**45-06-01.1-22. Effective date.**~~

~~This chapter is effective on January 1, 2020.~~

~~Insurers may offer any authorized plan upon approval by the commissioner.~~

~~**History:** Effective September 1, 2005.~~
~~**General Authority:** NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03~~
~~**Law Implemented:** NDCC 26.1-36.1~~

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION

FORM FOR CALENDAR YEAR

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

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a-1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)		
8.	Experienced Ratio Since Inception (*Ratio 2*)		
	Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

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

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.

[3] Includes Modal Loadings and Fees Charged.

[4] Excludes Active Life Reserves.

[5] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios".

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR

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

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 or credit against premiums to be used must be attached to this form.

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

Signature

Name - Please Type

Title - Please Type

Date

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

TYPE[1] SMSBP[2]

For the State of Company Name

NAIC Group Code NAIC Company Code

Address Person Completing Exhibit

Title Telephone Number

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15[+6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

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

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
[3]Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).
[4]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5]These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
[6]To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR

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

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15[+6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

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

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
[3]Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).
[4]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5]These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
[6]To include the earned premium for all years prior to as well as the 15th year prior to the current year.

APPENDIX B

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name:

Address:

Telephone Number:

Due March 1, annually

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

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

APPENDIX C

DISCLOSURE STATEMENTS
Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries That Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

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

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

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

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

This is not Medicare Supplement Insurance

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

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

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

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

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

Before You Buy This Insurance

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

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

Before You Buy This Insurance

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

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

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

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

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

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

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

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

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

Before You Buy This Insurance

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

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

Before You Buy This Insurance

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

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

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

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

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

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

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

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

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

Before You Buy This Insurance

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

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

Before You Buy This Insurance

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

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

Before You Buy This Insurance

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

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]
Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

ARTICLE 45-13
LINES OF INSURANCE

CHAPTER 45-13-01
LINES OF INSURANCE

45-13-01-01. Lines of insurance.

An insurance company or an insurance agent may apply to engage in insurance activities in one or more of the following lines of insurance:

1. Life and annuity.
2. Accident and health.
3. Property.
4. Casualty.
5. Variable life and annuity.

History: Effective January 1, 2000.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-05-02, 26.1-12-11, 26.1-26-11

45-13-01-02. Product types - Definition.

Each line of insurance is defined to include the following products:

1. Life and annuity includes:

Annuity/institutional investment	Equity/interest indexed annuity
Credit life	Equity/interest indexed universal life
Deferred annuity	Structured settlement annuity
Endowment	Term life
Guaranteed investment contract/pension plan	Universal life
Immediate annuity	Whole life

and similar products relating to life and annuity matters.

2. Accident and health includes:

Accident	Hospital indemnity
Accidental death	Hospital and surgical
Accidental death and dismemberment	Intensive care
Cancer	Involuntary unemployment
Civilian health and medical program	Long-term care

of the uniformed services supplement
Credit disability
Critical illness
Dental
Disability income
Excess loss
Family leave
Human immunodeficiency virus indemnity
Home health care
Major medical
Managed care/excess loss
Medical expense
Medicare supplement
Nursing home
Organ and tissue transplant
Prescription drug
Specified disease
Sickness
Stop-Loss Medical
Surgical expense
Vision

and similar products relating to accident and health matters.

3. **Property includes:**

Aircraft cargo
Aircraft hull
Allied lines
Auto commercial physical damage
Auto private passenger physical damage
Baggage
Boiler and machinery
Burglary and robbery
Business income
Cargo
Commercial inland marine
Commercial multi-peril
Commercial property
Credit
Credit card
Credit property
Crime
Crop
Crop hail
Crop supplements
Difference in conditions
Dwelling
Earthquake
Extended coverages
Fire
Fire and allied lines
Flood
Force placed
Glass
Lenders collateral
Livestock
Money and securities
Marine cargo
Marine hull
Mortgage guarantee
Multi-peril crop
Ocean marine
Personal floater
Personal inland marine
Pet
Rain
Theft
Vandalism
Vendors single interest

and similar products relating to property matters.

4. **Casualty includes:**

Aircraft liability
Asbestos abatement
Auto commercial liability
Auto private passenger liability
Auto warranty contract
Bail bonds
Bonds
Commercial excess liability
Commercial general liability
Commercial umbrella liability
Contractual liability
Directors and officers
Medical malpractice
Mechanical breakdown
Personal excess liability
Personal umbrella liability
Personal liability
Pollution liability
Premises and operations
Prepaid legal service
Product liability
Product recall
Products and completed operations

Design professional
Employers liability
Environmental impairment
Errors and omissions
Fidelity bonds
Fidelity insurance
Home warranty
Legal expense
Legal malpractice
Liquor and dram shop liability
Professional liability
Owners and contractors
Railroad protective
Ransom and extortion
Stop gap
Stop-loss liability
Surety
Title
Vehicle service contracts
Workers' compensation

and similar products relating to casualty matters.

5. Variable life and annuity includes:

Variable deferred annuity
Variable immediate annuity
Variable group annuity/pension plan
Variable life

and similar products relating to variable life and annuity matters.

History: Effective January 1, 2000; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-05-02.1

45-13-01-03. Products relating to more than one line of insurance - Combination products.

Certain insurance products may involve two or more lines of insurance. A company marketing a combination product must carry authorization for each of the respective lines of insurance. Products involving a combination of property and casualty lines of insurance include aircraft, auto commercial, auto private passenger, boat owners, business owners, condominium owners, farm owners, garage keepers, homeowners, mobile homeowners, special multi-peril, commercial multi-peril package, and tenants. Products involving a combination of life and annuity, and accident and health lines of insurance include multi-line credit, multi-line life and health, and multi-line association and employer. Products involving a combination of property and casualty, and accident and health lines of insurance include multi-line association and employer, travel, and multi-line credit.

History: Effective January 1, 2000.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-05-02.1, 26.1-12-11.1, 26.1-26-11.1

45-13-01-04. Prepaid legal service.

An insurance company that markets prepaid legal services must be licensed as a prepaid legal service organization and comply with chapter 26.1-19 of the North Dakota Century Code before transacting business in this state.

History: Effective January 1, 2000.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-19

CHAPTER 45-06-05.1
LONG-TERM CARE INSURANCE MODEL REGULATION

45-06-05.1-01. Applicability and scope. Except as otherwise specifically

provided, this chapter applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after March 1, 2004, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations, and all similar organizations. Certain provisions of this chapter apply only to qualified long-term care insurance contracts as noted. Policies delivered or issued for delivery in this state before March 1, 2004, are governed by chapter 45-06-05.

Additionally, this chapter is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

1. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

2. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

3. Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

History: Effective March 1, 2004; amended effective ___.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-02. Definitions. For the purpose of this chapter, the terms "long-term care insurance", "qualified long-term care insurance", "group long-term care insurance", "commissioner", "applicant", "policy", and "certificate" shall have the meanings set forth in North Dakota Century Code section 26.1-45-01. In addition, the following definitions apply:

1. a. "Exceptional increase" means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:

(1) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

(2) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

b. Except as provided in section 45-06-05.1-18, exceptional increases

are subject to the same requirements as other premium rate schedule increases.

c. The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

d. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

2. "Incidental", as used in subsection 10 of section 45-06-05.1-18, means that the value of the long-term care benefits provided is less than ten percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

3. "Qualified actuary" means a member in good standing of the American academy of actuaries.

4. "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-03. Policy definitions. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

1. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.

2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as

physicians and registered nurses, in order to maintain the individual's health status.

3. "Adult day care" means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

4. "Bathing" means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

5. "Cognitive impairment" means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

6. "Continence" means the ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.

7. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

8. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table or by a feeding tube or intravenously.

9. "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.

10. "Home health care services" means medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

11. "Medicare" means "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.

12. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional

disease or disorder.

13. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

14. "Skilled nursing care", ~~"intermediate care",~~ "personal care", "home care", "specialized care", "assisted living care", and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.

15. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

16. "Transferring" means moving into or out of a bed, chair, or wheelchair.

17. All providers of services, including but not limited to "skilled nursing facility", "extended care facility", ~~"intermediate care facility",~~ "convalescent nursing home", "personal care facility", "specialized care providers", "assisted living facility", and "home care agency", shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. ~~The~~ When the definition ~~may require~~ requires that the provider be appropriately licensed ~~or~~, certified, or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

History: Effective March 1, 2004; amended effective ___.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-04. Policy practices and provisions.

1. **Renewability.** The terms "guaranteed renewable" and "noncancelable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of section 45-06-05.1-06.

   a. A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancelable".

   b. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in

force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

c. The term "noncancelable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

d. The term "level premium" may only be used when the insurer does not have the right to change the premium.

e. In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

2. **Limitations and exclusions.** A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

a. Preexisting conditions or diseases;

b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of alzheimer's disease;

c. Alcoholism and drug addiction;

d. Illness, treatment, or medical condition arising out of:

(1) War or act of war (whether declared or undeclared);

(2) Participation in a felony, riot, or insurrection;

(3) Service in the armed forces or units auxiliary thereto;

(4) Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

(5) Aviation (this exclusion applies only to non-fare-paying passengers).

e. Treatment provided in a government facility, unless otherwise required by law, services for which benefits are available under medicare or other governmental program, except medicaid, any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

f. ~~Expenses for services or items available or paid under another long-term care insurance or health insurance policy; and~~

g. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount~~; and~~ .

h. (1) This subsection is not intended to prohibit exclusions and limitations by type of provider ~~or~~. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(a) When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

(b) When the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

(2) For purposes of this subdivision, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

i. This subsection is not intended to prohibit territorial limitations.

3. **Extension of benefits.** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may

be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

4. **Continuation or conversion.**

a. Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

b. For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

c. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and any group policy which it replaced, for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

d. For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. When the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans,

including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. When the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except when:

(1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) The terminating coverage is replaced not later than thirty-one days after termination, by group coverage effective on the day following the termination of coverage:

(a) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(b) The premium for which is calculated in a manner consistent with the requirements of subdivision f.

h. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent of incurred expenses. The

provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

j. Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon the insured individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

k. For the purposes of this section, a "managed care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

5. **Discontinuance and replacement.** If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

a. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

6. a. The premium charged to an insured shall not increase due to either:

(1) The increasing age of the insured at ages beyond sixty-five; or

(2) The duration the insured has been covered under the policy.

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required

under section 45-06-05.1-24, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

c. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under section 45-06-05.1-24, the initial annual premium shall be based on the reduced benefits.

7. **Electronic enrollment for group policies.**

a. In the case of a group defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(1) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(2) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and

(3) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of nonpublic personal financial information and nonpublic personal health information as defined by N.D Admin Code ~~article~~ 45-14-01 is maintained.

b. The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

History: Effective March 1, 2004; amended effective _____.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-05. Unintentional lapse. Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

1. a. Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received

from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

b. When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision a need not be met until sixty days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

c. Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subdivision a, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, and notice may not be given until thirty days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

2. Reinstatement. In addition to the requirement in subsection 1, a long-term care insurance policy or certificate shall include a provision that provides

for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past-due premium, when appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-06. Required disclosure provisions.

1. **Renewability.** Individual long-term care insurance policies shall contain a renewability provision.

   a. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancelable. This provision shall not apply to policies that do not contain a renewability provision and under which the right to nonrenew is reserved solely to the policyholder.

   b. A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

2. **Riders and endorsements.** Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.

3. **Payment of benefits.** A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and

customary", "reasonable and customary", or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

4. **Limitations.** If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations".

5. **Other limitations or conditions on eligibility for benefits.** A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in subsection 2 of North Dakota Century Code section 26.1-45-07 shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits".

6. **Disclosure of tax consequences.** With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

7. **Benefit triggers.** Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits". Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

8. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in subsection 5 of section 45-06-05.1-27, federal tax consequences, that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.

9. A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in

subsection 5 of section 45-06-05.1-27, federal tax consequences, that the policy is not intended to be a qualified long-term care insurance contract.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-07. Required disclosure of rating practices to consumers.

1. This section shall apply as follows:

   a. Except as provided in subdivision b, this section applies to any long-term care policy or certificate issued in this state on or after September 1, 2004.

   b. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following March 1, 2005.

2. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.

   a. A statement that the policy may be subject to rate increases in the future;

   b. An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;

   c. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

   d. A general explanation for applying premium rate or rate schedule adjustments that shall include:

      (1) A description of when premium rate or rate schedule adjustments will be effective, e.g., next anniversary date, next billing date, etc.; and

(2) The right to a revised premium rate or rate schedule as provided in subdivision c if the premium rate or rate schedule is changed; and

e. (1) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:

(a) The policy forms for which premium rates have been increased;

(b) The calendar years when the form was available for purchase; and

(c) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(2) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(3) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(4) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with paragraph 1.

(5) If the acquiring insurer in paragraph 4 files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in paragraph 4, the acquiring insurer shall make all disclosures required by this subdivision, including

disclosure of the earlier rate increase referenced in paragraph 4.

3. An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivisions a ~~through~~ and e of subsection 2. If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

4. An insurer shall use the forms in appendices B and F to comply with the requirements of subsections 2 and 3.

5. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection 2 when the rate increase is implemented.

History: Effective March 1, 2004. amended effective _____
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-08. Initial filing requirements.

1. This section applies to any long-term care policy issued in this state on or after September 1, 2004

2. An insurer shall provide the information listed in this subsection to the commissioner sixty ~~thirty~~ days prior to making a long-term care insurance form available for sale.

   a. A copy of the disclosure documents required in section 45-06-05.1-07; and

   b. An actuarial certification consisting of at least the following:

      (1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

      (2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(4) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include

(a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(b) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(c) A statement that the net valuation premium for renewal years does not increase, except for attained-age rating where permitted; and

(d) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations in which this does not occur:

[1] An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and

[2] If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subsection 3 based on a standard age distribution; and

(5) (a) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(b) A comparison of the premium schedules for similar policy forms that are currently available from the

insurer with an explanation of the differences.

3. a. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

   b. In the event the commissioner asks for additional information under this provision, the period in subsection 2 does not include the period during which the insurer is preparing the requested information.

History: Effective March 1, 2004; amended effective _____.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-08.1 Initial filing requirements.

1. This section applies to any long-term care policy issued in this state on or after **(INSERT DATE 6 MONTHS AFTER EFFECTIVE DATE).**

2. An insurer shall provide the information listed in this subsection to the commissioner sixty days prior to making a long-term care insurance form available for sale.

   a. A copy of the disclosure documents required in section 45-06-05.1-07; and

   b. An actuarial certification consisting of at least the following:

      (1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

      (2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

      (3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

      (4) A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in

subparagraph a and b

(a) A composite margin shall not be less than ten percent of lifetime claims.

(b) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.

(5) (a) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(b) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(6) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:

(a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

(b) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

c. An actuarial memorandum prepared, dated and signed by the member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:

(1) An explanation of the review performed by the actuary prior to making the statements in paragraphs 2 and 3 of

subdivision b of subsection 2.

(2) A complete description of pricing assumptions; and

(3) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in paragraph 1 of subdivision b of subsection 2 of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

(4) A demonstration that the gross premiums include the minimum composite margin specified in paragraph 4 of subdivision b of subsection 2.

History: Effective (INSERT DATE referenced in 1) .
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-09. Prohibition against post-claims underwriting.

1. All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

2. a. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

   b. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

3. Except for policies or certificates which are guaranteed issue:

a. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

> Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

> Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

c. Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the insurer shall obtain one of the following:

(1) A report of a physical examination;

(2) An assessment of functional capacity;

(3) An attending physician's statement; or

(4) Copies of medical records.

4. A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

5. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the national association of insurance commissioners in appendix A.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-10. Minimum standards for home health and community care benefits in long-term care insurance policies.

1. A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

   a. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

   b. By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community, or institutional setting before home health care services are covered;

   c. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

   d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the worker's licensure or certification;

   e. By excluding coverage for personal care services provided by a home health aide;

   f. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

   g. By requiring that the insured or claimant have an acute condition before home health care services are covered;

   h. By limiting benefits to services provided by medicare-certified agencies or providers; or

   i. By excluding coverage for adult day care services.

2. A long-term care insurance policy or certificate, if it provides for home

health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

3. Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-11. Requirement to offer inflation protection.

1. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

   a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent;

   b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

   c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

2. Where the policy is issued to a group, the required offer in subsection 1 shall be made to the group policyholder; except, if the policy is issued to a group defined in subdivision d of subsection 3 of North Dakota Century

Code section 26.1-45-01 other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

3. The offer in subsection 1 shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

4. a. Insurers shall include the following information in or with the outline of coverage:

   (1) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period.

   (2) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

   b. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

5. Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

6. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

7. a. Inflation protection as provided in subdivision a of subsection 1 shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection. The rejection may be either in the application or on a separate form.

   b. The rejection shall be considered a part of the application and shall state:

      I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

History: Effective March 1, 2004.

General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-12. Requirements for application forms and replacement coverage.

1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except when the coverage is sold without an agent, containing the questions may be used. With regard to a replacement policy issued to a group defined by subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate holder has been notified of the replacement.

   a. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

   b. Did you have another long-term care insurance policy or certificate in force during the last twelve months?

      (1) If so, with which company?

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

   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. Agents shall list any other health insurance policies they have sold to the applicant.

   a. List policies sold that are still in force.

   b. List policies sold in the past five years that are no longer in force.

3. Solicitations other than direct response. Upon determining that a sale will

involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE 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 accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (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 or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(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 that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of 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 or probationary periods. The insurer

will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care 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 Agent, Broker, or Other Representative)

[Typed Name and Address of Agent or Broker]

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

_____

(Applicant's Signature) (Date)

4. Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE 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 accident and sickness or long-term care insurance and

replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (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 or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care 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 in payment of 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 or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care 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. [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 thirty (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]

5. If replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address, including zip code. Notice shall be made within five working days from the date the application is received by the insurer or the date the

policy is issued, whichever is sooner.

6. Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. ~~If the policy being replaced is a life insurance policy, the insurer shall comply with the requirements of article 45-04~~. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with ~~both~~ the long-term care ~~and the life~~ insurance replacement requirements.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-13. Reporting requirements.

1. Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percentage of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percentage of the agent's total annual sales.

2. Every insurer shall report annually by June thirtieth the ten percent of its agents with the greatest percentages of lapses and replacements as measured by subsection 1. (Appendix G)

3. Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

4. Every insurer shall report annually by June thirtieth the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year. (Appendix G)

5. Every insurer shall report annually by June thirtieth the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year. (Appendix G)

6. Every insurer shall report annually by June thirtieth, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. (Appendix E)

7. For purposes of this section:

a. Subject to subdivision ~~c~~ b, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

b. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition;

c. "Policy" means only long-term care insurance; and

d. "Report" means on a statewide basis.

8. Reports required under this section shall be filed with the commissioner.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-14. Licensing. A producer is not authorized to sell, solicit, or negotiate with respect to long-term care insurance except as authorized by chapter 45-02-02 and North Dakota Century Code chapter 26.1-26.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-15. Discretionary powers of commissioner. The commissioner may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds;

2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

3. a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

b. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

c. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-16. Reserve standards.

1. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with North Dakota Century Code section 26.1-35-02. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

a. Definition of insured events;

b. Covered long-term care facilities;

c. Existence of home convalescence care coverage;

d. Definition of facilities;

e. Existence or absence of barriers to eligibility;

f. Premium waiver provision;

g. Renewability;

h. Ability to raise premiums;

i. Marketing method;

j. Underwriting procedures;

k. Claims adjustment procedures;

l. Waiting period;

m. Maximum benefit;

n. Availability of eligible facilities;

o. Margins in claim costs;

p. Optional nature of benefit;

q. Delay in eligibility for benefit;

r. Inflation protection provisions; and

s. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

2. When long-term care benefits are provided other than as in subsection 1, reserves shall be determined in accordance with ~~section 45-03-15-01~~ the minimum standards for sickness and accident insurance policies.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-17. Life Insurance Long-Term care Benefits

1. ~~This section shall apply to all long-term care insurance policies or certificates except those covered under sections 45-06-05.1-08 and 45-06-05.1-18.~~

2. ~~Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:~~

~~a. Statistical credibility of incurred claims experience and earned premiums;~~

~~b. The period for which rates are computed to provide coverage;~~

~~c. Experienced and projected trends;~~

~~d. Concentration of experience within early policy duration;~~

~~e. Expected claim fluctuation;~~

~~f. Experience refunds, adjustments, or dividends;~~

~~g. Renewability features;~~

~~h. All appropriate expense factors;~~

~~i. Interest;~~

~~j. Experimental nature of the coverage;~~

~~k. Policy reserves;~~

~~l. Mix of business by risk classification; and~~

~~m. Product features such as long elimination deductibles, high deductibles, and high maximum limits.~~

~~3.~~1. ~~Subsection 2 shall not apply to life insurance policies that accelerate benefits for long-term care.~~ A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of North Dakota Century Code sections 26.1-33-18 through 26.1-33-28;

c. The policy meets the disclosure requirements of subsections 4, 5, and 6 of North Dakota Century Code section 26.1-45-09;

d. Any policy illustration that meets the applicable requirements of the national association of insurance commissioners life insurance illustrations model regulation; and

e. An actuarial memorandum is filed with the insurance department that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include a percentage of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be

underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

History: Effective March 1, 2004; amended effective October 1, 2019 .
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-18. Premium rate schedule increases.

1. This section shall apply as follows:

   a. Except as provided in subdivision b, this section applies to any long-term care policy or certificate issued in this state on or after September 1, 2004.

   b. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following March 1, 2005.

2. An insurer shall request approval ~~provide notice~~ of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least thirty days prior to the notice to the policyholders and shall include:

   a. Information required by section 45-06-05.1-07;

   b. Certification by a qualified actuary that:

      (1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; ~~and~~

      (2) The premium rate filing is in compliance with the provisions of this section

   c. An actuarial memorandum justifying the rate schedule change

request that includes:

(1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

(a) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(b) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(c) The projections shall demonstrate compliance with subsection 3; and

(d) For exceptional increases:

[1] The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

[2] In the event the commissioner determines as provided in subdivision d of subsection 1 of section 45-06-05.1-02 that offsets may exist, the insurer shall use appropriate net projected experience;

(2) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(4) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; ~~and~~

(5) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and

(6) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in paragraph 4 of subdivision b of subsection 2 of section 45-06-05.1-08.1 is projected to be exhausted.

d. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

e. Sufficient information for review and approval of the premium rate schedule increase by the commissioner.

3. All premium rate schedule increases shall be determined in accordance with the following requirements:

a. Exceptional increases shall provide that seventy percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(1) The accumulated value of the initial earned premium times fifty-eight percent;

(2) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(3) The present value of future projected initial earned premiums times fifty-eight percent; and

(4) Eighty-five percent of the present value of future projected premiums not in paragraph 3 on an earned basis;

c. In the event that a policy form has both exceptional and other

increases, the values in paragraphs 2 and 4 of subdivision b will also include seventy percent for exceptional rate increase amounts; and

d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract. ~~for contract reserves as specified in section 45-03-15-01~~ The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

4. For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in paragraph 1 of subdivision c of subsection 2, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection 11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

5. If any premium rate in the revised premium rate schedule is greater than two hundred percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in paragraph 1 of subdivision c of subsection 2, shall be filed for approval by the commissioner every five years following the end of the required period in subsection 4. For group insurance policies that meet the conditions in subsection 11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

6. a. If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection 3, the commissioner may require the insurer to implement any of the following:

(1) Premium rate schedule adjustments; or

(2) Other measures to reduce the difference between the projected and actual experience.

b. In ~~determine~~ determining whether the actual experience adequately matches the projected experience, consideration should be given to

paragraph 5 of subdivision c of subsection 2, if applicable.

7. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

   a. A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection 8; and

   b. The original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to subsection 3 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent been used in the calculations described in paragraphs 1 and 3 of subdivision b of subsection 3.

8. a. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

      (1) The rate increase is not the first rate increase requested for the specific policy form or forms;

      (2) The rate increase is not an exceptional increase; and

      (3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

   b. In the event significant adverse lapsation has occurred and is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(1) The offer shall:

(a) Be subject to the approval of the commissioner;

(b) Be based on actuarially sound principles, but not be based on attained age; and

(c) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(a) The maximum rate increase determined based on the combined experience; and

(b) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent.

9. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subsection 8, prohibit the insurer from either of the following:

a. Filing and marketing comparable coverage for a period of up to five years; or

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

10. Subsections 1 through 9 shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subsection 2 of section 45-06-05.1-02, if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(1) North Dakota Century Code sections 26.1-33-18 through 26.1-33-28;

(2) North Dakota Century Code chapter 26.1-34-02; and

~~(3) Sections 45-04-02-01 through 45-04-02-08;~~

c. The policy meets the disclosure requirements of subsections 4, 5, and 6 of North Dakota Century Code section 26.1-45-09;

d. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(1) Policy illustrations as required by sections 45-04-01.1-~~01 through 45-04-01.1-10 plus bulletins 96-2 and 97-2;~~ and

(2) Disclosure requirements in sections 45-04-02-~~01 through 45-04-02-08; and~~

e. An actuarial memorandum is filed with the insurance department that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include a percentage of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the

average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

11. Subsections 6 and 8 shall not apply to group insurance policies as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 when:

a. The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or

b. The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than twenty percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

History: Effective March 1, 2004; amended effective _____.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-19. Filing requirement. Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to North Dakota Century Code section 26.1-45-03, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-20. Filing requirements for advertising.

1. Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the insurance commissioner of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three years from the date the advertisement was first used.

2. The commissioner may exempt from these requirements any advertising form or material when, in the commissioner's opinion, this requirement may not be reasonably applied.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-21. Standards for marketing.

1. Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

   a. Establish marketing procedures and agent training requirements to assure that:

      (1) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and

      (2) Excessive insurance is not sold or issued.

   b. 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 long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

   c. Provide copies of the disclosure forms required in subsection 3 of section 45-06-05.1-07 (appendices B and F) to the applicant.

   d. Inquire and otherwise make every reasonable effort to identify

whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

e. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with subsection 1.

f. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that the program is available and the name, address, and telephone number of the program.

g. For long-term care health insurance policies and certificates, use the terms "noncancelable" or "level premium" only when the policy or certificate conforms to subdivision c of subsection 1 of section 45-06-05.1-04.

h. Provide an explanation of contingent benefit upon lapse provided for in subdivision c of subsection 4 of section 45-06-05.1-24 and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium payment periods in subdivision d of subsection 4 of section 45-06-05.1-24.

2. In addition to the practices prohibited in North Dakota Century Code section 26.1-04-03, 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 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 insurance agent or insurance company.

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

3. a. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in subdivision b of subsection 3 of North Dakota Century Code section 26.1-45-01, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

b. The insurer shall file with the insurance department the following material:

(1) The policy and certificate;

(2) A corresponding outline of coverage; and

(3) All advertisements requested by the insurance department.

c. The association shall disclose in any long-term care insurance solicitation:

(1) The specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees, and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members; and

(2) A brief description of the process under which the policies and the insurer issuing the policies were selected.

d. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

e. The board of directors of associations selling or endorsing long-

term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

f. The association shall also:

(1) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

(2) Actively monitor the marketing efforts of the insurer and its agents; and

(3) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

(4) Paragraphs 1 through 3 shall not apply to qualified long-term care insurance contracts.

g. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.

h. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.

i. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of North Dakota Century Code section 26.1-04-03.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-22. Suitability.

1. This section shall not apply to life insurance policies that accelerate benefits for long-term care.

2. Every insurer, health care service plan, or other entity marketing long-term care insurance (the "issuer") shall:

   a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

   b. Train its agents in the use of its suitability standards; and

   c. Maintain copies of its suitability standards and make them available for inspection upon request by the commissioner.

3. a. To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following into consideration:

      (1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

      (2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

      (3) The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

   b. The issuer and, when an agent is involved, the agent shall make reasonable efforts to obtain the information set out in subdivision a. The efforts shall include presentation to the applicant, at or prior to application, the "long-term care insurance personal worksheet". The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in appendix B, in not less than twelve-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

   c. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

   d. The sale or dissemination outside the company or agency by the

issuer or agent of information obtained through the personal worksheet in appendix B is prohibited.

4. The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.
5. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance.

6. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in appendix C, in not less than twelve-point type.

7. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

8. The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-23. Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-24. Nonforfeiture benefit requirement.

1. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

2. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of North Dakota Century Code section 26.1-45-14:

   a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection 5; and

   b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

3. If the offer required to be made under North Dakota Century Code section 26.1-45-14 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subdivision d of subsection 4 shall still apply.

4. a. After rejection of the offer required under North Dakota Century Code section 26.1-45-14, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

   b. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

   c. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age and the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase
Percent Increase Over

Issue Age	Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

d. A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below

based on the insured's issue age, the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased, and the ratio in paragraph 2 of subdivision f is forty percent or more. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by subdivision c and where both are triggered, the benefit provided shall be at the option of the insured.

e. On or before the effective date of a substantial premium increase as defined in subdivision c, the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection 5. This option may be elected at any time during the one hundred twenty-day period referenced in subdivision c; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period referenced in subdivision c shall be deemed to be the election of the offer to convert in paragraph 2 unless the automatic option in paragraph 3 of subdivision f applies.

f. On or before the effective date of a substantial premium increase as defined in subdivision d, the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent of the amount payable in effect immediately prior to lapse times the

ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty-day period referenced in subdivision d; and

(3) Notify the policyholder or certificateholder that a default or lapse at any time during the one hundred twenty-day period referenced in subdivision d shall be deemed to be the election of the offer to convert in paragraph 2 if the ratio is forty percent or more.

g. For any long-term care policy issued in this state on or after **[insert date that is 6 months after adoption of the amended regulation]**.

(1) In the event the policy or certificate was issued at least twenty years prior to the effective date of the increase, a value of zero percent shall be used in place of all values in the above table; and

(2) Values above one hundred percent in the table in subdivision c shall be reduced to one hundred percent.

5. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subdivision c of subsection 4 but not subdivision d of subsection 4, are described in this subsection:

a. For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty, and at least three percent per year beyond age fifty.

b. For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subdivision c.

c. The standard nonforfeiture credit will be equal to one hundred percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit

for that duration. However, the minimum nonforfeiture credit shall not be less than thirty times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection 6.

d. (1) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) Notwithstanding paragraph 1, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(a) The end of the tenth year following the policy or certificate issue date; or

(b) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

e. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

6. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

7. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

8. The requirements set forth in this section shall become effective twelve months after adoption of this provision and shall apply as follows:

a. Except as provided in ~~subdivision~~ subdivisions b and c, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

b. For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, which policy was in force at the time this amended regulation became effective, the provisions of this section shall not

apply.

c. The last sentence in subsection 3 and subdivisions d and f of subsection 4 shall apply to any long-term care insurance policy or certificate issued in this state after six months after their adoption, except new certificates on a group policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 one year after adoption.

9. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the ~~loss ratio~~ requirements of section 45-06-05.1-17 or 45-06-05.1-18, treating the policy as a whole.

10. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision c or d of subsection 4, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

11. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

a. The nonforfeiture provision shall be appropriately captioned;

b. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and

c. The nonforfeiture provision shall provide at least one of the following:

(1) Reduced paid-up insurance;

(2) Extended term insurance;

(3) Shortened benefit period; or

(4) Other similar offerings approved by the commissioner.

History: Effective March 1, 2004; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-25. Standards for benefit triggers.

1. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

2. a. Activities of daily living shall include at least the following as defined in section 45-06-05.1-03 and in the policy:

   (1) Bathing;

   (2) Continence;

   (3) Dressing;

   (4) Eating;

   (5) Toileting; and

   (6) Transferring; and

   b. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subdivision a as long as they are defined in the policy.

3. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections 1 and 2.

4. For purposes of this section, the determination of a deficiency shall not be more restrictive than:

   a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

   b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order

to protect the insured or others.

5. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

6. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

7. The requirements set forth in this section shall be effective March 1, 2005, and shall apply as follows:

   a. Except as provided in subdivision b, the provisions of this section apply to a long-term care policy issued in this state on or after the effective date of the amended regulation.

   b. For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 that was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-26. Additional standards for benefit triggers for qualified long-term care insurance contracts.

1. For purposes of this section, the following definitions apply:

   a. (1) "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

      (a) Being unable to perform, without substantial assistance from another individual, at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or

      (b) Requiring substantial supervision to protect the individual from threats to health and safety due to

severe cognitive impairment.

(2) The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

b. "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the secretary of the treasury.

c. "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

d. "Qualified long-term care services" means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

2. A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

3. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity or to severe cognitive impairment.

4. Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection 3 shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the secretary of the treasury.

5. Certifications required pursuant to subsection 3 may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a

licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

6. Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-27. Standard format outline of coverage. This section implements, interprets, and makes specific the provisions of subsection 2 of North Dakota Century Code section 26.1-45-09 in prescribing a standard format and the content of an outline of coverage.

1. The outline of coverage shall be a freestanding document, using no smaller than ten-point type.

2. The outline of coverage shall contain no material of an advertising nature.

3. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

4. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

5. Format for outline of coverage:

[COMPANY NAME]
[ADDRESS - CITY AND STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

   This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified, long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

   OR

   Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified, long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. Terms Under Which the Policy OR Certificate May Be Continued in Force or Discontinued.

   a. [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

      (1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS

POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancelable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

b. [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.]

c. [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

a. [Provide a brief description of the right to return - "free look" provision of the policy.]

b. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available

from the insurance company.

a. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government, or any state government.

b. [For direct response] [insert company name] is not representing Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

a. [Covered services, related deductibles, waiting periods, elimination periods, and benefit maximums.]

b. [Institutional benefits, by skill level.]

c. [Noninstitutional benefits, by skill level.]

d. Eligibility for Payment of Benefits.

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

a. Preexisting conditions;

b. Noneligible facilities and provider;

c. Noneligible levels of care (e.g., unlicensed providers, care, or treatment provided by a family member, etc.);

d. Exclusions and exceptions; and

e. Limitations.].

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 9 above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

a. That the benefit level will not increase over time;

b. Any automatic benefit adjustment provisions;

c. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

d. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations; ~~and~~

e. And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.].

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[a. State the total annual premium for the policy; and

b. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[a. Indicate if medical underwriting is used; and

b. Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-28. Requirement to deliver shopper's guide.

1. A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

   a. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

   b. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

2. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under North Dakota Century Code section 26.1-45-09.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

45-06-05.1-29. Penalties. In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

History: Effective March 1, 2004.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-45

Appendix A – No change
Appendix B – Whole new version from Model
Appendix C – changes
Appendix D – No change
Appendix E – changes
Appendix F – Whole new version from Model
Appendix G – No change

Appendix C
Disclosure Form

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.
- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance". Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Appendix E
Sample Claims Denial Format

Claims Denial Reporting Form
Long-Term Care Insurance

For the State of _____
For the Reporting Year of _____

Company Name: _____ Due: June 30 annually
Company Address: _____
_____
Company NAIC Number: _____
Contact Person: _____ Telephone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

☐ Per Claimant – counts each individual who makes one or a series of claim requests.

☐ Per Transaction – counts each claim payment request.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

Inforce Data

	State Data	Nationwide Data[1]
Total Number of Inforce Policies [Certificates] as of December 31st		

Claims & Denial Data

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid Due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (line 2 minus line 3 minus line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (line 5 divided by line 1)		
7	Number of Long-Term Care Claims Denied Due to:		
8	• Long-Term Care Services Not Covered Under the Policy[2]		
9	• Provider/Facility Not Qualified Under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the ~~date~~ data for claims reported and denied for your state are small in number.

2. Example - Home health care claim filed under a nursing home only policy.

3. Example - A facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

4. Examples - A benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

Appendix F
Potential Rate Increase Disclosure Form

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-Term Care Insurance Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and approved for an increase [is][are] [on the application] [$].

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. Potential Rate Revisions:

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates CANNOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.

   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)

   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)

- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you did not buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here is how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture **Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture** (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)	
Issue Age	**Increase Over Initial Premium**
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%

79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which subdivisions d and f of subsection 4 of section 45-06-05.1-24 are applicable].

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can chose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers for a Substantial Premium Increase
Percent Increase

Issue Age	Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

CHAPTER 45-12-01
NORTH DAKOTA BOILER RULES

Subsections 4 and 23 of Section 45-12-01-01 are amended as follows:

45-12-01-01. Definitions.

4. "A.S.M.E. code" means the boiler and pressure vessel construction code of the American society of mechanical engineers of which sections I, II, IV, V, VIII (divisions 1, 2 and 3), IX, and X, ~~2017~~ 2019 edition, are hereby adopted by the commissioner and incorporated by reference as a part of this article. A copy of the American society of mechanical engineers code is on file at the office of the boiler inspection program. The American society of mechanical engineers code may be obtained from the American society of mechanical engineers headquarters at 2 park avenue, New York, New York 10016-5990 or from www.asme.org.

23. "National board inspection code" means the manual for boiler and pressure vessel inspectors supplied by the national board. The national board inspection code, ~~2017~~ 2019 edition, is hereby adopted by the commissioner and incorporated by reference as a part of this article. Copies of this code may be obtained from the national board at 1055 crupper avenue, Columbus, Ohio 43229.

History: Effective June 1, 1994; amended effective April 1, 1996; January 1, 2000; October 1, 2002; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; January 1, 2014; April 1, 2017; October 1, 2019.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

CHAPTER 45-12-03
GENERAL REQUIREMENTS

Subsection 4 of Section 45-12-03-07 is amended as follows:

45-12-03-07. Automatic low-water fuel cutoff or water-feeding device.
1. Each automatically fired steam or vapor system boiler must be equipped with an automatic low-water cutoff located to automatically cut off the fuel supply when the surface of the water falls to the lowest safe waterline. For other than electric and miniature boilers, each automatically fired steam or vapor system boiler must be equipped with at least two low-water fuel cutoffs, one of which must be readily testable. One low-water fuel cutoff must be set to function ahead of the other. Functioning of the lower of the controls shall cause safety shutdown and lockout. The manual reset may be incorporated into the lower cutoff control.

Where a reset device is separate from the low-water fuel cutoff, a means shall be provided to indicate actuation of the low-water fuel cutoff. The manual reset device may be of the instantaneous type or may include a time delay of not more than three minutes after the fuel has been cut off. A system may incorporate a time delay component with the low-water fuel cutoff device to prevent short cycling. A time delay must not exceed the manufacturer's recommended timing, or ninety seconds, whichever is less. A high pressure boiler regularly attended by a full-time operator is not considered as automatically fired, and is not required to be equipped with low-water fuel cutoffs. For other than electric boilers, the primary low-water fuel cutoff for low pressure steam boilers must be a float type that can be readily tested.

2. If a water-feeding device is installed, it must be constructed so that the water inlet valve cannot feed water into the boiler through the float chamber and located to supply requisite feedwater. The lowest safe waterline should not be lower than the lowest visible part of the water glass.

3. Such fuel or feedwater control device may be attached directly to a boiler or to the tapped openings provided for attaching a water glass directly to a boiler, provided that for low pressure boilers such connections from the boiler are nonferrous tees or Ys not less than one-half-inch [12.7-millimeter] pipe size between the boiler and the water glass, so that the water glass is attached directly and as close as possible to the boiler; the straight tapping of the Y or tee to take the water glass fittings, and the side outlet of the Y or tee to take the fuel cutoff or water-feeding device. The ends of all nipples must be reamed to full-size diameter.

4. Designs embodying a float and float bowl must have a vertical straight drainpipe at the lowest point in the water equalizing pipe connections by which the bowl and the equalizing pipe can be flushed and the device tested. This drainpipe and connections must be not less than national pipe standard (NPS) ~~1~~ 3/4.

History: Effective June 1, 1994; amended effective April 1, 1996; January 1, 2000; January 1, 2006; July 1, 2019.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

CHAPTER 45-12-08
HEATING, LOW PRESSURE, AND HOT WATER SUPPLY BOILERS - NEW INSTALLATIONS

A new section to chapter 45-12-08 is added as follows:

Section
45-12-08-01 Requirements
45-12-08-02 Clearances

45-12-08-01. Requirements.

1. Unless exempt by this article, a heating or low pressure boiler may not be installed in this state unless it has been constructed, inspected, and stamped to conform with section IV of the American Society of Mechanical Engineers Boiler and Pressure Vessel Code and is approved, registered, and inspected in accordance with the requirements of this article.

2. All new installation boilers, including reinstalled boilers, must be installed in accordance with the requirements of the American Society of Mechanical Engineers Code and this article.

3. Hot water supply boilers may not be installed unless constructed and approved in accordance with the American gas association, the American national standards institute, or the American society of mechanical engineers.

4. All new boilers, except those exempt by law, to be installed in North Dakota must be reported to the chief boiler inspector by the owner or user, and by the installer.

History: Effective June 1, 1994.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

45-12-08-02. Clearances.

1. All new boiler installations must be designed to allow for normal operation, cleaning, and inspections. Heating boilers shall have at least three feet [.91 meters] of clearance on each side of the boiler from adjacent walls, structures, or other equipment.

2. Alternative clearances in accordance with the manufacturer's service and maintenance recommendations are subject to acceptance by the Chief Inspector."

History: Effective October 1, 2019
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

CHAPTER 45-03-12
INVESTMENT, CAPITAL, AND SURPLUS REQUIREMENTS

45-03-12-01. Capital and surplus requirements.

In the reasonable exercising of the commissioner's discretion, additional capital and surplus may be required based upon the type, volume, and nature of insurance business transacted.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-02, 26.1-06.1-01, 26.1-10-05

45-03-12-02. Investments.

All companies doing business in the state shall have an investment portfolio which is diversified as to type and issue and which maintains liquidity.

If the commissioner considers it desirable in order to get a proper evaluation of the investment portfolio of an insurer that has admitted assets exceeding ten million dallars, the commissioner may require that investments in mutual funds or other investment companies be treated for purposes of this chapter and for the individual investment limitations imposed under subsection a of section 21 of NDCC 26.1-05-19 as if the investor owned directly its proportional share of the assets owned by the mutual fund or investment company.

History: Effective January 1, 1992; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-02, 26.1-05-19, 26.1-06.1-01, 26.1-10-06

45-03-12-03. Admitted assets.

Repealed effective December 1, 2001.

45-03-12-04. Securities lending, repurchase, reverse repurchase, and dollar roll transactions.

An insurer may enter into a securities lending, repurchase, reverse repurchase, and dollar roll transaction with business entities, subject to the following requirements:

1. The insurer's board of directors shall adopt a written plan for engaging in investment practices consistent with the requirements of the written plan in section 45-03-12-05 and which specifies guidelines and objectives to be followed, such as:

   a. A description of how cash received will be invested or used for general corporation purposes of the insurer;

   b. Operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

   c. The extent to which the insurer may engage in these transactions.

   The board shall review and assess the insurer's technical investment and administrative capabilities and expertise before adopting a written plan concerning an investment practice.

2. For purposes of this section, acceptable collateral means:

   a. As to securities lending transactions and for the purpose of calculating counterparty exposure amount, cash, cash equivalents, letters of credit, direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or any agency of the United States, or by the federal national mortgage association or the federal home loan mortgage corporation;

   b. As to repurchase transactions, cash, cash equivalents, and direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or an agency of the United States, or by the federal national mortgage association or the federal home loan mortgage corporation; and

   c. As to reverse repurchase transactions, cash and cash equivalents.

3. The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement shall require that each transaction terminate no more than one year from its inception or upon the earlier demand of the insurer. The agreement shall be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer, if the agent is a primary dealer in United States government securities recognized by the federal reserve bank of New York and if the agreement:

   a. Requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

   b. Prohibits securities lending transactions under the agreement with the agent or its affiliates.

4. Cash received in a transaction under this section shall be invested in accordance with North Dakota Century Code section 26.1-05-19 and in a manner that recognizes the liquidity needs of the transaction or used by the insurer for its general corporate purposes. For so long as the transaction remains outstanding, the insurer, its agent, or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the federal reserve, depository trust company, or other securities depositories approved by the commissioner:

   a. Possession of the acceptable collateral;

   b. A perfected security interest in the acceptable collateral; or

   c. In the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral.

5. For purposes of calculations made to determine compliance with this subsection, no effect will be given to the insurer's future obligation to resell securities, in the case of a repurchase transaction, or to repurchase securities, in the case of a reverse repurchase transaction. An insurer shall not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

   a. The aggregate amount of securities then loaned, sold to, or purchased from any one business entity counterparty under this section would exceed five percent of its admitted assets. In calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement; or

   b. The aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this section would exceed forty percent of its admitted assets.

6. In a dollar roll transaction, the insurer shall receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

7. The amount of collateral required for securities lending, repurchase, and reverse repurchase transactions is the amount required pursuant to the provision of the national association of insurance commissioners accounting practices and procedures manual described in section 45-03-15-01.

8. Securities acquired by an insurer in a repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

History: Effective December 1, 2001; amended effective October 1, 2002.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-05-19

45-03-12-05. Authorization of investments by the board of directors.

An investment is deemed to be authorized by an insurer's board of directors prior to its acquisition if the investment is acquired and held subject to the following requirements:

1. The board of directors shall adopt a written plan for acquiring and holding investments and for engaging in investment practices that specifies guidelines as to the quality, maturity, and diversification of investments and other specifications including investment strategies intended to assure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs, and its capital and surplus. The board shall review and assess the insurer's technical investment and administrative capabilities and expertise before adopting a written plan concerning an investment strategy or investment practice.

2. For purposes of this section, investment strategy means the techniques and methods used by an insurer to meet its investment objectives, such as active bond portfolio management, passive bond portfolio management, interest rate anticipation, growth investing, and value investing.

3. Investments shall be acquired and held under the supervision and direction of the board of directors and the board shall evidence by formal resolution, at least annually, that it has determined whether all investments have been made in accordance with delegations, standards, limitations, and investment objectives prescribed by the board or a committee of the board charged with the responsibility to direct its investments.

4. On no less than a quarterly basis, the board of directors or committee of the board of directors shall:

   a. Receive and review a summary report on the insurer's investment portfolio, its investment activities, and investment practices engaged in under delegated authority, in order to determine whether the investment activity of the insurer is consistent with its written plan; and

   b. Review and revise, as appropriate, the written plan.

5. In discharging its duties under this section, the board of directors shall require that records of any authorizations or approvals, other documentation as the board may require, and reports of any action taken under authority delegated under the written plan be made available on a regular basis to the board of directors.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-05-18

CHAPTER 45-10-02
GENERAL PROVISIONS

45-10-02-01. Definitions.

For the purposes of this chapter, the following definitions apply in addition to the definitions set forth in North Dakota Century Code chapter 23-37:

1. "Antifreeze" is not a petroleum product.

2. "Farm tank" means a tank located on a tract of land devoted to the production of crops or for raising animals and associated residences and improvements. A farm tank must be located on the farm property.

3. "Portable tank" means any storage tank, along with its piping and wiring, that is not stationary or affixed including, but not limited to, tanks which are on skids.

4. "Residential tank" means a tank located on property used primarily for dwelling purposes.

5. "Surface impoundment" means a natural topographic depression, manmade excavation, or diked area formed primarily of earthen materials.

6. Storage tanks used for collecting crude oil are considered flowthrough process tanks and are excluded from coverage.

~~6.~~ 7. "Department" means department of environmental quality.

History: Effective November 25, 1991; amended effective June 1, 1994; April 1, 2014; October 1, 2019.
General Authority: NDCC 23-37-05, 28-32-02
Law Implemented: NDCC 23-37

45-10-02-02. Tank registration.

On an annual basis (fiscal year July first through June thirtieth), the administrator will mail to all prior fund registrants and any other known petroleum tank owners and operators in North Dakota a registration letter and billing notice. The letter will explain the function of the fund and the requirement that the tank owner or operator must have all tanks owned or operated registered and all fees paid prior to a petroleum release in order to be eligible for reimbursement. In the event of a petroleum release, no payment will be made to an owner or operator of a registered tank unless the owner or operator has complied with all other state and federal regulations regarding petroleum tanks.

History: Effective November 25, 1991; amended effective June 1, 1994.
General Authority: NDCC 23-37-05, 28-32-02
Law Implemented: NDCC 23-37-17

45-10-02-03. Registration fee.

1. An annual registration fee is due and payable on July 1, 1991, and on July first of each successive year thereafter or from the date a new tank was installed if it was after April 1991, to be in compliance with this section. The period of registration must run from July first to June thirtieth to coincide with the fiscal year of North Dakota.

2. No reregistration or fee modification will be made during any registration year when an owner or operator removes a tank or replaces an underground tank with an aboveground tank within a registration year. The renewal billing will reflect the tank status change.

History: Effective November 25, 1991; amended effective June 1, 1994; January 1, 2000; April 1, 2014.
General Authority: NDCC 23-37-05, 28-32-02
Law Implemented: NDCC 23-37-17

45-10-02-04. Notification of release procedures.

Upon receiving notice of a release, the administrator shall:

1. Verify that the tank and all other tanks owned or operated by the operator are registered with the fund.

2. Record the release information in the registration file for the location.

3. Verify that the ~~state~~ department ~~of health~~ has received notice of the release.

4. If the owner or operator has not registered all of the tanks owned and operated by the operator at the location of the release, send a letter of denial to the owner or operator with a copy to the ~~state~~ department ~~of health~~and close the file.

5. Obtain verification from the owner or operator that the affected tank, equipment, components, material, or dispenser is compatible with and meets state requirements for the petroleum product stored and dispensed. If not compatible, send letter of denial to the owner operator with a copy to the ~~state~~department ~~of health~~and close file.

6. If all tanks are registered and the affected tank, piping, fitting, or dispenser is compatible, notify the owner of the fund's claim filing procedures and send the tank owner or operator the fund's tank release guidelines with an application for reimbursement.

History: Effective November 25, 1991; amended effective June 1, 1994; August 1, 2000; April 1, 2014; October 1, 2019.
General Authority: NDCC 23-37-05, 28-32-02
Law Implemented: NDCC 23-37-10, 23-37-19

45-10-02-05. Procedures for investigation of claims.

In each release investigation, the administrator shall:

1. Investigate the location and cause of the release.

2. Interview persons with knowledge of the release.

3. Examine records and documentation concerning the release, including documentation of the corrective action taken and expenses incurred.

4. Prepare a written report determining the validity of the claim and the eligible cleanup expenses.
5. Complete other tasks as required.

History: Effective November 25, 1991; amended effective August 1, 2000; April 1, 2014.
General Authority: NDCC 23-37-05, 28-32-02
Law Implemented: NDCC 23-37-18, 23-37-20, 23-37-23

45-10-02-06. Reimbursement.

1. The fund will reimburse only reasonable and necessary eligible cleanup expenses as determined by the administrator in consultation with the ~~state~~department ~~of health~~and only if all tanks are properly registered prior to the discovery of the release.
2. No payment will be made from the fund unless a completed application form has been received by the administrator.
3. Eligible expenses for corrective action include the following:
   a. Labor.
   b. Testing.
   c. Use of machinery.
   d. Materials and supplies.
   e. Professional services.
   f. Expenses incurred through direction of the ~~state~~department ~~of health~~.
   g. Any other expenses the administrator and the board deem to be reasonable and necessary to remedy cleanup of the release and satisfy liability to any third party.
   h. Consultant fees if authorized by the ~~state~~department ~~of health~~.
4. The following will not be considered eligible expenses under this regulation:
   a. The cost of replacement, repair, and maintenance of affected tanks and associated piping.
   b. Pumping out of any product, including water, from any tanks which need to be removed.
   c. The cost of upgrading existing affected tanks and associated piping.
   d. The loss of income, profits, or petroleum product.
   e. Decreased property value.
   f. Bodily injuries or property damages except for injuries or damages suffered by third parties.
   g. Attorney's fees.
   h. Costs associated with preparing, filing, and prosecuting an application for reimbursement or assistance under this regulation.

i. The costs of making improvements to the facility beyond those that are required for corrective action, including replacing concrete, asphalt, equipment, or buildings. Any cleanup costs resulting from negligence or misconduct on the part of the owner or operator.

j. Marked-up costs.

k. Costs in excess of those considered reasonable by the administrator ~~fund~~.

l. Fines or penalties imposed by order of federal, state, or local government.

m. Finance charges, interest charges, or late payment charges.

5. To determine what expenses are reasonable and necessary, the owner, operator, or landowner must bid the excavation and consultant work. The lowest bid that meets the requirements of the ~~state~~ department ~~of health~~will be deemed by the administrator to be the reasonable cost for that project. The bid must be submitted according to the fund's excavation and consultant worksheets. Additional work over and above the original bid will be reimbursed according to unit costs on the original bid.

6. The administrator may provide partial payments prior to the final determination of the amount of the loss, if it is determined that the cleanup is proceeding according to the proposed workplan of the ~~state~~department ~~of health~~for the site assessment. The payment may be made to the owner, operator, or landowner or that person's assigned representative if the appropriate assignment form is submitted to the administrator with appropriate documentation verifying that the work has been completed by the assignee.

7. Requests for reimbursement ~~All claims for payment~~are subject to the availability of funds in the petroleum tank release compensation fund and must be submitted, with completed worksheets, no later than one year after the work unit or task has been completed to be eligible.

8. Prior to payment for any loss, the owner, operator, or landowner shall subrogate to the fund all rights, claims, and interest which the owner, operator, or landowner has or may have against any party, person, persons, property, corporation, or other entity liable for the subject loss, and shall authorize the fund to sue, compromise, or settle in the name of the owner, operator, or landowner or otherwise, all such claims. The subrogation agreement required by this section must be prescribed and produced by the administrator.

9. Reimbursement will be considered when the owner, operator, or landowner has submitted complete excavation or consultant worksheets along with legible copies of all invoices and a description of the work performed.

10. The owner, operator, or landowner must submit, prior to any payment, evidence that the amounts shown on the invoices for which the payment is requested were either paid in full by the owner, operator, or landowner or, if the owner, operator, or landowner has assigned the right to receive payment from the fund, that a contractor hired has expended time and materials for which payment must be made. This must include documentation that the work has been completed by the assignee.

11. Prior to payment, the administrator must be satisfied that the corrective action taken has met all state regulations and that the corrective action has satisfied public health, welfare, and environmental concerns.

History: Effective November 25, 1991; amended effective June 1, 1994; August 1, 2000; December 1, 2001; April 1, 2014; October 1, 2019.
General Authority: NDCC 23-37-05, 28-32-02
Law Implemented: NDCC 23-37-18, 23-37-20, 23-37-23, 23-37-24

45-10-02-06.1. Reimbursement disputes.

If the fund administrator denies or reduces payment to a tank owner, operator, or landowner, the tank owner, operator, or landowner may request a review by the board by filing a written request and supporting documentation with both the administrator and the board within thirty days of receiving a proof of loss. The board shall issue a written decision concerning the issues in dispute within thirty days of receiving the written notice and supporting documentation. The board's decision must provide the basis of its decision. If after review by the board a dispute still exists, the claimant or the administrator may appeal the board decision to the commissioner within 30 days of the board's decision. The decision of the commissioner may be appealed under North Dakota Century Code chapter 28-32.

History: Effective August 1,2000; amended effective December 1, 2001; October 1, 2019.
General Authority: NDCC 23-37-05, 28-32-02;
Law Implemented: NDCC 23-37

45-10-02-07. Third-party damages.

No reimbursement may be made for damage to employees as defined by the North Dakota Workers' Compensation Act or agents of the owner or operator.

History: Effective November 25, 1991.
General Authority: NDCC 23-37-05, 28-32-02
Law Implemented: NDCC 23-37-26, 23-37-27

45-10-02-08. Board.

The administrator shall advise the board of the fund's general operations and review claims either through written correspondence, telephone conference calls, or meetings. The board shall meet at least once each half of each calendar year.

History: Effective November 25, 1991; amended effective August 1, 2000; December 1, 2001.
General Authority: NDCC 23-37-05, 28-32-02
Law Implemented: NDCC 23-37-03

45-10-02-09. Report to legislative assembly and governor.

Repealed effective April 1, 2014.

CHAPTER 45-03-15
ACCOUNTING PRACTICES AND PROCEDURES

Section
45-03-15-01 Accounting Practices and Procedures
45-03-15-02 Reporting of Financial Information
45-03-15-03 Annual Statement Filing
45-03-15-04 Acceptable Media for Annual Statement Filing

45-03-15-01. Accounting practices and procedures.

Every insurance company doing business in this state shall file with the commissioner, pursuant to North Dakota Century Code section 26.1-03-07, the appropriate national association of insurance commissioners annual statement blank, prepared in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the March 2015~~5~~9 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance.

History: Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001; March 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; April 1, 2014; January 1, 2016; October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-03-07, 26.1-03-11.1

45-03-15-02. Reporting of financial information.

Every insurance company licensed to do business in this state shall transmit to the commissioner and to the national association of insurance commissioners its most recent financial statements compiled on a quarterly basis, within forty-five days following the calendar quarters ending March thirty-first, June thirtieth, and September thirtieth. The financial statements must be prepared and filed in the form prescribed by the commissioner and in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the March 2015~~5~~9 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance. The commissioner may exempt any company or category or class of companies from the filing requirement.

History: Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001; March 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; April 1, 2014; January 1, 2016; October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-03, 26.1-03-07, 26.1-03-11.1

45-03-15-03. Annual statement filing.

Every insurance company operating in more than one state shall file all annual and quarterly statements with the national association of insurance commissioners, through media acceptable to the commissioner, unless the commissioner makes a specific finding that an insurer, or type of insurer, is exempt from this filing requirement.

History: Effective October 1, 1995; amended effective April 1, 1996; December 1, 1998.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-03-07, 26.1-03-11.1

45-03-15-04. Acceptable media for annual statement filing.

~~The following media are acceptable to the commissioner for~~ tThe filing of annual and quarterly statements with the national association of insurance commissioners and every insurance company subject to the requirements of section 45-03-15-03 shall use the national association of insurance commissioners internet filing website ~~one of these media~~ in making the filings

required by that section:.

~~1. Diskette; or~~

~~2. Electronic transmission of data, including the internet.~~

History: Effective December 1, 1998; amended effective October 1, 2019.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-03-07, 26.1-03-11.1

CHAPTER 45-03-25
CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION

45-03-25-01. Authority

This chapter is promulgated pursuant to the authority granted by North Dakota Century Code 26.1-10.3.

45-03-25-02. Purpose

The purpose of this chapter is to set forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD), deemed necessary by the commissioner to carry out the provisions of the Corporate Governance Annual Disclosure Model Act (North Dakota Century Code 26.1-10.3).

45-03-25-03. Definitions

1. "Commissioner" means the North Dakota insurance commissioner.

2. "Insurance group" for the purpose of this chapter, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in North Dakota Century Code 26.1-10-01.

3. "Insurer" the term "insurer" shall have the same meaning as set forth in North Dakota Century Code 26.1-29-02, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

4. "Senior Management" the term "senior management" shall mean any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer ("CEO"), Chief Financial Officer ("CFO"), Chief Operations Officer ("COO"), Chief Procurement Officer ("CPO"), Chief Legal Officer ("CLO"), Chief Information Officer ("CIO"), Chief Technology Officer ("CTO"), Chief Revenue Officer ("CRO"), Chief Visionary Officer ("CVO"), or any other "C" level executive.

45-03-25-04. Filing Procedures

1. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD pursuant to North Dakota Century Code 26.1-10.3 shall, no later than June 1 of each calendar year, submit to the Commissioner a CGAD that contains the information described in 45-03-25-05.

2. The CGAD must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's Board of Directors (hereafter "Board") or the appropriate committee thereof.

3. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Commissioner to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.

4. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

5. Notwithstanding Subsection A of this Section, and as outlined in Section 3 of the Corporate Governance Annual Disclosure Model Act, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

6. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in Section 5. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

7. Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

45-03-25-05. Contents of Corporate Governance Annual Disclosure

1. The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

2. The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following.

   a. The Board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and

   b. The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of Chief Executive Officer (CEO) and Chairman of the Board within the organization.

3. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

a. How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.

b. How an appropriate amount of independence is maintained on the Board and its significant committees.

c. The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.

d. How the insurer or insurance group identifies, nominates and elects members to the Board and its committees. The discussion should include, for example:

(1) Whether a nomination committee is in place to identify and select individuals for consideration.

(2) Whether term limits are placed on directors.

(3) How the election and re-election processes function.

(4) Whether a Board diversity policy is in place and if so, how it functions.

e. The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

4. The insurer or insurance group shall describe the policies and practices for directing Senior Management, including a description of the following factors:

a. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

(1) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.

(2) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

b. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(1) Compliance with laws, rules, and regulations; and

(2) Proactive reporting of any illegal or unethical behavior.

c. The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example:

(1) The Board's role in overseeing management compensation programs and practices.

(2) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(3) How compensation programs are related to both company and individual performance over time;

(4) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(5) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted;

(6) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

d. The insurer's or insurance group's plans for CEO and Senior Management succession.

5. The insurer or insurance group shall describe the processes by which the Board, its committees and Senior Management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

a. How oversight and management responsibilities are delegated between the Board, its committees and Senior Management;

b. How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps that Senior Management is taking to monitor and manage those risks;

c. How reporting responsibilities are organized for each critical risk area. The description should allow the Commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by Senior Management and the Board. This description may include, for example, the following critical risk areas of the insurer:

(1) Risk management processes (An ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act, North Dakota Century Code 26.1-10.2);

(2) Actuarial function;

(3) Investment decision-making processes;

(4) Reinsurance decision-making processes;

(5) Business strategy/finance decision-making processes;

(6) Compliance function;

(7) Financial reporting/internal auditing; and

(8) Market conduct decision-making processes.

45-03-25-06. Severability Clause

If any provision of this chapter, or the application of this chapter to any person or circumstance, is held invalid, the validity shall not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

History: Effective October 1, 2019
General Authority: NDCC 26.1-10.3
Law Implemented: NDCC 26.1-10.3

CHAPTER 45-02-04
INSURANCE CONTINUING EDUCATION

45-02-04-01. Purpose. Insurance continuing education courses must promote educational activities that advance one's professional expertise and keep the individual abreast with the insurance industry. Routine meetings, luncheons, and gatherings not advertised and developed as insurance continuing education events will not qualify for insurance continuing education credit. This does not apply to industry, regulatory or legislative meetings held by or on behalf of a professional insurance association in conjunction with 26.1-26-31.9 of the North Dakota Century Code.

History: Effective July 1, 1986; amended effective October 1, 2019.
General Authority: NDCC 26.1-26-49; 26.1-31.9; 26.1-26-02
Law Implemented: NDCC 26.1-26-49

45-02-04-02. Definitions. As used in this chapter, unless the context or subject matter otherwise requires:

1. "Commissioner" means the insurance commissioner.

2. "Coordinator" means an individual who is responsible for monitoring insurance continuing education offerings and who serves as the liaison for students, instructors, and the commissioner.

3. "Instructor" means an individual who teaches, lectures, or otherwise instructs an insurance continuing education offering.

4. "Insurance continuing education" means an accredited educational experience derived from participation in approved lectures, seminars, and correspondence courses in areas related to insurance. This education must be designed to improve the professional skills of the participant and upgrade the standard of all insurance licensees to better serve the public.

5. "Insurance lines of authority" for insurance continuing education purposes include life and annuity insurance, accident and health insurance, property insurance, casualty insurance, personal lines insurance, and crop hail insurance.

6. "Insurance producer or licensee" means a natural person licensed by this state for the type and kind of insurance being marketed and for which licensing examinations are required.

7. "License" means the authorization issued to an individual by the insurance commissioner to act as an insurance producer.

8. "License applicant" means a person not currently licensed or an insurance producer seeking a license for a line or lines of insurance for which the person is not currently licensed.

9. "National insurance education program" means a curriculum dedicated to the continuance of insurance education, leading to a nationally accepted insurance designation, such as a chartered property casualty underwriter (CPCU), a chartered life underwriter (CLU), or a registered health underwriter (RHU).

10. "Provider" means a natural person, firm, institution, partnership, corporation, or association offering or providing insurance education.

History: Effective July 1, 1986; amended effective December 1, 2001; January 1, 2006; January 1, 2008.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-49

45-02-04-03. General rules.

1. **Course requirements.** The insurance continuing education course requirements include an educational presentation involving insurance fundamentals, policies, laws, risk management, or other courses which are offered in a process of instruction approved by the commissioner as expanding skills and developing knowledge to better serve the insurance buying public.

2. **Nonapproved courses.** The following course content will not qualify for insurance continuing education credit:

a. Prelicensure training
b. Prospecting
c. Recruiting
d. Sales, Skills and Promotions
e. Motivation
f. Psychology
g. Communication Skills
h. Supporting office and machine skills
i. Personnel management

The above listing does not limit the commissioner's authority to disapprove any application which fails to meet the standards for course approval.

3. **Licensee responsibility.** Each licensee shall be responsible for maintaining original records of the licensee's insurance continuing education certificates of attendance for a period of one year from the last reporting deadline. Such records shall be made available to the commissioner upon request.

4. **Correspondence course credit.** Credit received by an insurance producer for a correspondence course must be based on successful completion of the course as prescribed by the provider and approved by the commissioner.

5. **Reciprocity.** The commissioner may approve credit for insurance-related courses approved by the North Dakota real estate commission and the North Dakota state bar association for insurance continuing education purposes.

6. **Credit hour.** A credit hour means sixty minutes of time, of which at least fifty minutes must be instruction, with a maximum of ten minutes break.

a. Credit hours for insurance continuing education will not be approved in increments of less than one-half hour.

b. Neither students nor instructors may earn credit for attending or instructing at any subsequent offering of an insurance continuing education course more than once during a reporting period.

7. **Course audit.** The commissioner or an authorized representative reserves the right to audit insurance continuing education offerings with or without notice to the provider.

8. **Class attendance.** No certificate of attendance will be issued to an insurance continuing education participant who is absent for more than ten percent of the classroom hours.

9. **Examinations.** Course examinations will not be required for insurance continuing education courses, unless required by the provider.

10. **Textbooks.** Textbooks are not required for insurance continuing education courses. All course materials must contain accurate and current information relating to the subject matter being taught.

11. **Approval of course offerings.** The commissioner requires providers of insurance continuing education courses to provide the following:

a. To the commissioner on a commissioner-approved form prior to course offerings:

(1) An application for course approval of an insurance continuing education course fifteen business days prior to course offering;

(2) A complete course outline designating individual topics and the amount of time devoted to each area being taught;

(3) An application for coordinator approval; and

(4) A fifty dollar per course filing fee;

b. A class roster to the commissioner using a method prescribed by the commissioner fifteen days subsequent to completion of all insurance continuing education courses; and

c. To course participants subsequent to course offerings provide a course attendance certificate (form SFN 10923) to all students successfully completing an approved insurance continuing education course.

Upon review by the commissioner, providers will receive a copy of the course application indicating approval or denial, credit hours assigned, and a course certification number. Course certification numbers must be used on all insurance continuing education certificates, correspondence, and advertisements.

12. **Provider management responsibility.** Providers of insurance continuing education courses are responsible for the actions of their respective instructors and coordinators.

13. **Course approval after the fact.** Credit may be granted for a course after the fact provided such courses are properly submitted and

approved by the commissioner. Subsequent approval depends on course content and is not automatic or guaranteed.

14. **Advertising.** Courses may not be advertised in any manner unless approval has been granted, in writing, by the commissioner.

a. All advertising relating to approved course offerings shall contain the following statement: "This course has been approved by the insurance commissioner for (insert hours) of insurance continuing education credit."

b. Advertising must be truthful, clear, and not deceptive or misleading.

15. **Fees.** Fees for courses must be reasonable and clearly identifiable to students. If a course is canceled for any reason, all fees must be returned within thirty days of cancellation.

16. **Adequate facility.** Each course of study must be conducted in a classroom or other facility which will adequately and comfortably accommodate the faculty and the number of students enrolled. The provider may limit the number of students enrolled in a course.

History: Effective July 1, 1986; amended effective January 1, 2000; December 1, 2001; January 1, 2006; January 1, 2008; July 1, 2012.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-49

45-02-04-04. General powers of commissioner. The commissioner may deny, censure, suspend, or revoke the approval of a provider, coordinator, instructor, or course if it is determined not to be in compliance with the statute or rules governing the offering of insurance continuing education courses. The commissioner may also refuse to approve courses conducted by specific providers if the commissioner determines that past offerings have not been in compliance with insurance continuing education laws and rules.

History: Effective July 1, 1986; amended effective January 1, 2006; January 1, 2008.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-49

45-02-04-05. Course coordinator.

1. **General requirement.** Each course of study must have at least one coordinator, approved by the commissioner, who is responsible for supervising the program and assuring compliance with the statutes and rules governing the offering of insurance continuing education courses.

2. **Qualifications.** Course coordinators shall possess at least one of the following qualifications:

CHAPTER 45-06-16
SHORT-TERM LIMITED DURATION INSURANCE

45-06-16-01. Definitions

1. "Short-term limited-duration health insurance plan" means health insurance coverage provided pursuant to an insurance policy or group certificate of insurance that has an expiration date specified in the policy that is no longer than six months after the original effective date of the policy and, taking into account any renewals or extensions, has a duration of not more than twelve months in total.

2. "Application" includes an application for individual coverage or a group enrollment form.

History: Effective October 1, 2019.
General Authority: NDCC § 26.1-36-38
Law Implemented: NDCC § 26.1-36-49

45-06-16-02. Application Requirements

All applications for short-term limited duration insurance policies shall contain clear and unambiguous questions designed to ascertain the reason for health condition of the applicant as follows:

1. Do you have comprehensive major medical coverage in-force as of the date of this application?

2. Are you aware that this insurance coverage is NOT comprehensive major medical coverage?

3. Why are you purchasing a short-term, limited duration plan? (Please check all that apply)

   a. I am not eligible for ACA marketplace tax subsidies.
   b. I cannot afford an ACA marketplace plan.
   c. I do not use a lot of healthcare, therefore, I don't feel I need a comprehensive major medical plan.
   d. Other

4. Do you understand that this policy may not have network doctors and therefore may result in a bill to me for additional charges not covered by a doctor that is out-of-network with this plan?

History: Effective October 1, 2019.
General Authority: NDCC § 26.1-36-38
Law Implemented: NDCC § 26.1-36-49

45-06-16-03. Disclosure Requirements

1. Disclosure statement - All short-term limited-duration policies as defined under NDCC 26.1-36-49 shall contain the following disclosure on front cover page of the policy, the certificate of coverage, and the application in large print.

THIS IS NOT A COMPREHENSIVE MAJOR MEDICAL INSURANCE POLICY.

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH CERTAIN FEDERAL MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. PLEASE CAREFULLY REVIEW THE TERMS OF YOUR POLICY TO MAKE SURE YOU ARE AWARE OF ANY EXCLUSIONS OR LIMITATIONS REGARDING COVERAGE OF PRE-EXISTING CONDITIONS OR HEALTH BENEFITS (SUCH AS HOPITALIZATION, EMERGENCY SERVICES, MATERNITY CARE, PREVENTATIVE CARE, PRESCRIPTION DRUGS, HABILITATIVE AND REHABILITATIVE CARE, AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR POLICY MIGHT ALSO HAVE LIFETIME AND/OR ANNUAL DOLLAR LIMITS ON HEALTH BENEFITS. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MAY HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO OBTAIN OTHER HEALTH INSURANCE COVERAGE.

2. Outline of coverage - The outline of coverage must provide the following information:

   a. Types of benefits provided
   b. Cost sharing provisions and maximum limits
   c. Describe how benefit payments are determined
   d. Exclusions and limitations
   e. Renewability provisions

History: Effective October 1, 2019.
General Authority: NDCC § 26.1-36-38
Law Implemented: NDCC § 26.1-36-49

45-06-16-04. Standards of Marketing

An issuer through its producers, must:

1. Provide an outline of coverage to applicants at the time application is presented to the prospective applicant and must obtain an acknowledgment of receipt of the outline from the applicant.

2. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

3. Establish marketing procedures to assure full disclosure is given to the insured.

4. Establish auditable procedures for verifying compliance with this subsection.

History: Effective October 1, 2019.
General Authority: NDCC § 26.1-36-38
Law Implemented: NDCC § 26.1-36-49