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TABLE OF CONTENTS

TITLE 3

Accountancy, Board of

SEPTEMBER 2001

CHAPTER 3-02-02

3-02-02-01. Examination fees. The following examination fees have been established by the board for the certified public accountants examination:

1. One hundred ~~forty~~ seventy-five dollars ~~at--the--time--an applicant-files-an-application~~ to take the full examination effective with the November 2001 examination and two hundred thirty dollars effective with the November 2002 examination.

2. ~~Forty~~ Forty-five dollars per subject for each reexamination provided the applicant has already passed two other parts of the examination, effective with the November 2001 examination, and sixty dollars per subject effective with the November 2002 examination.

History: Amended effective July 1, 1981; July 1, 1985; July 1, 1987; July 1, 1991; March 1, 1995; September 1, 2001.
General Authority: NDCC 43-02.2-03
Law Implemented: NDCC 43-02.2-04

3-02-02-02. Fee for certificate without examination. The fee for the issuance of a certificate when the board has waived the examination shall be one hundred forty dollars. The fee for a resident to transfer examination grades shall be one hundred forty dollars. Individuals intending to enter the state under the substantial equivalency provisions of North Dakota Century Code section 43-02.2-04.1 shall register and pay a registration fee of one hundred forty dollars prior to commencing work in this state.

~~An applicant for a certificate, under subsection 3 of North Dakota Century Code section 43-02.2-04, may be granted a certificate, without meeting all conditions therein, if the applicant has had four years of experience outside of this state in the practice of public accounting after passing the uniform CPA examination, and within the ten years preceding application, or has had substantially equivalent experience in the judgment of the board.~~

History: Amended effective March 1, 1995; September 1, 1997; July 1, 1999; September 1, 2001.
General Authority: NDCC 43-02.2-03
Law Implemented: NDCC 43-02.2-04

CHAPTER 3-05-02

3-05-02-01. Submission of reports. When so directed by the board, each firm which performs compilation ~~or review~~ services but no audit or review services, shall furnish to the board, with respect to each office which performs compilation ~~or review~~ services for clients in this state, one copy of ~~each of the following kinds of reports~~ a compilation report plus accompanying financial statements issued by that office during the preceding twelve-month period, if any such report ~~of such kind~~ was issued during such period~~:~~.

~~1.--A compilation report, including accompanying financial statements; if~~ If the firm has produced a compilation with full disclosures, then this type of compilation must be furnished~~;~~.

~~2.--A review report, including accompanying financial statements; and~~

~~3.~~ Related workpapers are to be furnished also, when requested by the board.

History: Effective June 1, 1988; amended effective July 1, 1991; March 1, 1995; September 1, 1997; September 1, 2001.
General Authority: NDCC 43-02.2-03
Law Implemented: NDCC 43-02.2-06

3-05-02-01.1. Peer review. When directed by the board, a firm which performs audit or review services, is required to undergo a peer review conforming to the standards of the AICPA peer review program, or a program deemed comparable in the opinion of the board. A copy of the report of such review and the letter of acceptance, plus the letter of comments and letter of response, if any, are to be submitted to the board.

History: Effective July 1, 1991; amended effective March 1, 1995; September 1, 1997; September 1, 2001.
General Authority: NDCC 43-02.2-03
Law Implemented: NDCC 43-02.2-06

TITLE 13

Department of Financial Institutions

DECEMBER 2001

STAFF COMMENT: Article 13-06 contains all new material and is not underscored so as to improve readability.

ARTICLE 13-06

DEFERRED PRESENTMENT SERVICE PROVIDERS

CHAPTER 13-06-01
DEFERRED PRESENTMENT SERVICE PROVIDERS

13-06-01-01. Definitions. As used in this chapter:

1. "Annual percentage rate" means a measure of the cost of credit, expressed as a yearly rate, as calculated under the Truth in Lending Act [15 U.S.C. 1601].

2. "Date of the transaction" means the date on which the written agreement is signed and the funds are advanced.

3. "Deferred presentment service provider" means an entity often referred to as a payday loan, payday advance, or deferred deposit loan provider.

4. "Financial responsibility" means a financial condition, at a minimum, that is a positive net worth as disclosed in the most recent financial statement.

5. "Generally accepted accounting practices" means procedures adopted by the American institute of certified public accountants and federal accounting standards boards.

6. "Maturity date" means the date agreed upon by a licensee and check maker to present a check for final payment. "Maturity date" may also be referred to as date of negotiation, date of presentment, or presenting a check for payment.

7. "Principal shareholders" means any shareholders which control directly or indirectly the power to vote twenty-five percent or more of the voting shares of the corporation.

8. "Transaction" means a deferred presentment service transaction.

9. "Unencumbered assets" means any assets when a market value can be readily determined and which are not pledged or held under a security interest.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-01

13-06-01-02. Financial responsibility. In order to determine financial responsibility, applicants shall provide with the application the most current fiscal year-end financial statements, prepared in accordance with generally accepted accounting principles. The applicant shall also include financial statements for the most recent quarter end.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10

Law Implemented: NDCC 13-08-03

13-06-01-03. Determination of bond amount. Each applicant shall maintain a bond issued by a surety company authorized to do business in this state. The bond amount is generally based on the high point of the receivables of the applicant's business, as of the most recent March thirty-first report. If an applicant has more than one licensed location, the bond amount is based on the combined receivables of all locations as of the most recent March thirty-first report. The initial bond amount is based on projected receivables.

A minimum of a twenty thousand dollar bond is based on receivables less than one hundred thousand dollars; a minimum of a fifty thousand dollar bond is based on receivables from one hundred thousand dollars to two hundred fifty thousand dollars; and a minimum of a seventy-five thousand dollar bond is based on receivables greater than two hundred fifty thousand dollars.

However, the commissioner may require a higher bond in the commissioner's sole discretion. The basis for determining the bond amount or any increases in the amount will be based, in part, on:

1. Financial responsibility of the licensee.

2. Issuance of any enforcement action against the licensee by this state or any other governmental entity.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-03(4)

13-06-01-04. Application. A photograph of the exterior and interior of the business location must be included with the initial application. The application must include fingerprint cards from principal shareholders and managers. Any application received that is incomplete will be returned to the applicant and will not be considered for a license until the completed application is submitted in full.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-04, 13-08-10
Law Implemented: NDCC 13-08-04(3), 13-08-06(1)

13-06-01-05. Posting fees. Licensees shall post a notice of fees in a conspicuous location in a minimum font size of forty-eight point.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-06(1)

13-06-01-06. Change of control. The change of control application must be filed and approved by the commissioner prior to the date the change of ownership is consummated. The department shall act on the application within sixty days from the date the application is received but may extend the review period for good cause. The new applicant must meet the same criteria required of all deferred presentment service provider applicants, including payment of the investigation fee of four hundred dollars. At the commissioner's discretion, the commissioner may require a new license application.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-07, 13-08-10
Law Implemented: NDCC 13-08-07

13-06-01-07. Reports of commissioner. Written reports in this section must be on a form prescribed by the commissioner. Written reports that are required by the commissioner to be filed within fifteen calendar days of the occurrence of the events are:

1. On or before April fifteenth of each year, the licensee shall file with the commissioner a financial report as of March thirty-first, relating to all transactions made by the licensees.

2. A report of the name change of the licensee must be filed with the department prior to the name change.

3. Whenever a licensee desires to change the licensed place of business, the licensee shall provide the department with the following prior to the relocation:

   a. A written notice providing the complete address of the new location.

   b. Photographs of both the exterior and interior of the new location.

   c. A written sworn statement that the new location will not share the premises with that of another business.

   d. A report of a change of management of the licensee.

   e. The original license for reissue.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-08(4)

13-06-01-08. Regulations - Examinations. For purposes of any investigation, examination, or proceeding under North Dakota Century Code chapter 13-08, the commissioner may require the production of any

books, papers, correspondence, memoranda, agreements, or other documents or records which the commissioner deems relevant or material to the examination, investigation, or proceeding.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-10

13-06-01-09. Retention of records. The records must be kept for six years from the date of the last transaction. Records must be located at the licensee's business location. With the commissioner's prior written approval, the licensee may retain records at a location other than the licensed location. The licensee shall make a written request to retain records at a location other than the licensed location which shall include the following:

1. The address of the offsite location.

2. A contact person and telephone number at the offsite location.

3. An acknowledgment that the licensee will pay for all examination expenses.

4. A statement that all books, records, and account information shall be made available within seventy-two hours after the department's request at either the licensed location or the offsite location.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-11

13-06-01-10. Required records. Every licensee shall keep the following records:

1. **Transaction register.**

   a. The transaction register must contain the original entry and be a permanent record, and must show for every transaction the account number, date of transaction, maturity date, date of rollover and new maturity date if any, amount of transaction, name of check maker and all other accountholders on that account, and the amount of fees expressed in dollar amount.

   b. The transaction register must be kept numerically by transaction number in the order made and must have headings for each of the items required.

2. **An individual account record.** An individual account record must be kept for each check maker. Such account record must

show the name and address of the check maker, co-makers, transaction number, date of transaction, maturity date, and fee expressed in dollar amount.

3. **File of all original papers.** A separate file shall be maintained for each check maker and shall contain the written agreement and acknowledged copy of the disclosure statement of transaction. Evidence of disclosure must be retained for six years from the date of the transaction. When prior written approval has been obtained from the commissioner, a licensee may maintain these files in any medium or format that accurately reproduces original documents or papers.

4. **Check copies.** Copies of checks received in the deferred presentment service transaction.

5. **Cash book.** All receipts and disbursements, of any amount whatsoever, must be entered in the cash book or equivalent record on the day they occur. Separate headings must be provided for payments and fees collected from check makers. The cash book must be a record of all details of income and disbursements, including all entries to individual accounts of check makers.

6. **Alphabetical record of check makers and co-makers.** The alphabetical record must show the account number and the name of each check maker and co-maker who is currently indebted to the licensee, with sufficient information to locate the account record.

7. **Permanent file.** Each licensee shall maintain a permanent file which includes the following:

   a. A copy of all correspondence sent to or received from the department within the past twenty-four months.

   b. A copy of the last two examination reports and any related correspondence.

8. **Check record.** A record must be retained of each check presented for negotiation, including checks deposited, cashed, and checks presented directly to the check maker's issuing bank.

9. **Renewal record.** A record must be retained of all renewals as a separate record.

10. **Returned checks.** A record must be retained of all checks returned for nonsufficient funds, account closed, or stop payment.

11. **Rescinded transactions.** A record must be retained of all rescinded transactions by check maker as a separate record.

Erasures may not be made in the payment and charge sections of any account records. In case of error, a line must be drawn in ink through the improper entry and the correct entry made on the following line. The entries on the record must correspond with the receipts given the check maker.

Records of transactions made under North Dakota Century Code chapter 13-08 must be kept separate or readily identifiable from other types of business conducted in the office.

Electronic data processing, combination forms, and special office systems may be used if in accordance with generally accepted accounting practices and must contain the information required by this section.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-11

13-06-01-11. Procedures.

1. Each document used in the transaction process bearing evidence of indebtedness, and executed by a check maker, must bear a transaction number.

2. The name and address of the licensee making the transaction must appear on all disclosure statements, all written agreements, and any other documents associated with the transaction.

3. At the time any transaction is made, the licensee shall give to the maker of the check a written disclosure statement. The written disclosure statement must be in a font size not less than ten point. The disclosure statement must be signed by the check maker.

4. The disclosure statement must contain the following items, which must be explained to and initialed by the check maker:

   a. The schedule of fees charged;

   b. No security held as condition of transaction or method of collection; and

   c. Information required under federal law:

      (1) Truth in Lending Act [15 U.S.C. 1601].

      (2) Privacy notice under Federal Trade Commission Regulation - Privacy of Consumer Financial Information [16 CFR, part 313].

      (3) Equal Credit Opportunity Act [15 U.S.C. 1691-1691f].

5. A licensee may not take any written agreement or other document related to the transaction in which the blanks are not filled in completely before the proceeds of the transaction are delivered. All spaces or sections not used in the preparation of legal documents must be ruled out or designated as "none" or "N/A".

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-12(1)

13-06-01-12. Credit practices. Any deferred presentment service provider that contracts with a third-party collection service in an attempt to collect nonsufficient funds, account closed, stop payment orders, or any other returned checks shall provide in the contract a notice of the twenty dollar maximum allowed returned check charge collected per year per check maker.

A licensee while collecting or attempting to collect an alleged debt may not engage in any of the following acts:

1. Using or threatening to use force, violence, or physical harm to a check maker or the check maker's family or property.

2. Threatening arrest or criminal prosecution when no basis for such action lawfully exists.

3. Threatening the seizure, attachment, and sale of a check maker's property when such action can only be taken pursuant to court order unless disclosure is made that prior court proceedings are required.

4. Disclosing or threatening to disclose information adversely affecting a check maker's reputation for creditworthiness with knowledge or reason to know such information is false.

5. Threatening to initiate or initiating communication with a check maker's employer.

6. Communicating or threatening to communicate with a check maker or the check maker's family with such unreasonable frequency as to constitute harassment or at times reasonably considered to be unusual hours or known to be inconvenient.

7. Using profane, obscene, or abusive language with a check maker or the check maker's family.

8. Disclosing or threatening to disclose information relating to a check maker's indebtedness to any other person except when such other person has a legitimate business need for the information.

9. Disclosing or threatening to disclose information concerning the existence of a debt, which the licensee knows to be reasonably disputed by the check maker, without disclosing the fact that the debt is disputed.

10. Attempting or threatening to attempt enforcement of a right or remedy with knowledge or reason to know that the right or remedy does not exist.

11. Using any form of communication simulating legal or judicial process which gives the appearance of being authorized, issued, or approved by a governmental agency or official or attorney at law when it is not.

12. Using badges, uniforms, or other indicia of any governmental agency or official except as authorized by law.

13. Misrepresenting the amount of the debt alleged to be owed.

14. Representing that an alleged debt may be increased by the addition of attorney's fees, investigation fees, or any other fees or charges when there is no contractual or statutory authorization for such addition.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-12(7)

13-06-01-13. General.

1. The deferred presentment service check must be presented for payment within forty-six days of the original transaction date.

2. When a payment is made in cash, the licensee shall give a receipt to the check maker.

3. Unless otherwise authorized by subsection 14 of North Dakota Century Code section 13-08-12, no other business may be conducted at the licensed location unless authorized in writing by the commissioner. The commissioner's authorization will be predicated upon the licensee's agreement to the following:

   a. That the authorization will not conceal nor facilitate concealment of an evasion of North Dakota Century Code chapter 13-06.

   b. To comply with any applicable state or federal statutes and regulations.

c. To obtain any license or registration required by a federal, state, or local governmental agency to engage in the other business authorized.

d. That the commissioner may examine all records and investigate any or all transactions of the licensee.

e. That the commissioner retains the right, upon notice and opportunity to be heard, to alter, amend, or revoke another business authorization.

f. That if any federal or state statute or regulation enacted thereafter prohibits the activity, the authorization shall become null and void immediately.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-12

13-06-01-14. Written agreement. At the time any transaction is made and funds are advanced, the licensee shall give to the maker of the check a signed written agreement. The written agreement must contain the following:

1. The name of the licensee.
2. The name and address of the check maker.
3. The date of the transaction.
4. The amount of the check.
5. The total amount of fees charged, expressed as a dollar amount and as an annual percentage rate.
6. The date of negotiation of the check.
7. The signature of the check maker.
8. A statement that a licensee may not renew a transaction more than once.
9. A statement that the renewal fee cannot exceed twenty percent of the amount being renewed.
10. The maximum term of the transaction, including the renewal, may not exceed forty-five days.
11. The term of the renewal period may not be less than fifteen days.

12. A renewal agreement must be contained in a separate section, as part of the original written agreement or in other form as approved by the commissioner. The renewal agreement must restate the transaction date, the amount of the check paid to the check maker, the fee charged in dollars and annual percentage rate, and maturity date.

13. A statement containing the right of rescission must be printed immediately above the signature line of the written agreement and must be in a minimum of ten-point font. A space must be provided for the check maker to initial that notice of the right of rescission was received.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-12

13-06-01-15. Surrender of license. A licensee may surrender a deferred presentment service business license by delivering to the commissioner written notice that the license is surrendered. The surrender does not affect the licensee's civil or criminal liability for acts committed prior to such surrender, affect the liability of the surety on the bond, or entitle such licensee to a return of any part of the annual license fee or fees. The commissioner may establish procedures for the disposition of the books, accounts, and records of the licensee and may require such action as the commissioner deems necessary for the protection of the maker of checks that are outstanding at the time of surrender of the license.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-10

13-06-01-16. Advertising. A licensee may not make reference in any form of advertising such as newspapers, circulars, letters, radio, or other media to "low rates", or "lowest rates", or "lowest cost", or to indicate by direct or indirect means through such expression as "low cost", "lower cost", or "easier to repay", or by any device that the charges for a transaction are low. Licensees may advertise "new reduced rates" or "reduced rates", or similar phrases for not more than sixty days after the effective date of such reduction in rates.

A licensee may not advertise in a false, misleading, or deceptive manner or imply or indicate that the rates or charges for loans made are "approved", "set", or "established" by the department of financial institutions.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-10

13-06-01-17. Enforcement. The commissioner may publish information concerning any violation of the statute or any rule, regulation, or order of the commissioner under the statute.

The department or department agents may confiscate control of any record for purposes of verification of bond claims.

History: Effective July 1, 2001.
General Authority: NDCC 13-08-10
Law Implemented: NDCC 13-08-10

TITLE 24

Electrical Board

DECEMBER 2001

CHAPTER 24-02-01

24-02-01-01. Definitions. The terms used throughout this chapter have the same meaning as in the National Electrical Code except:

1. "Correction order" means a notice, written by an electrical inspector to the person responsible for the electrical installation, stating violations and noncompliance of rules and regulations as listed, must be corrected within a designated time.

2. "Qualified person" means a person licensed by the North Dakota state electrical board.

3. "Recreational vehicle site" means any plot of ground intended for the connection of recreational vehicles.

~~3.~~ 4. "Wiring certificate" means a document consisting of one or more copies certifying that certain electrical wiring and equipment was installed in conformity with the rules and regulations of the electrical board.

History: Amended effective January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-02. General statement of policy and interpretative rules. There are three categories of licensed electricians recognized by the electrical board.

1. Licensed electricians and the qualifications required for each to apply for examination:

   a. A master electrician must have at least one year's experience working as a licensed journeyman electrician under the supervision of a contracting master electrician.

   b. A journeyman electrician must have at least four years' (8,000 hours total, maximum 2,000 hours per year) experience registered as an apprentice electrician (of which up to eighteen months may apply under the qualifications of a class B electrician) under the supervision of a contracting master licensed electrician in an area where electrical construction work is done in the jurisdiction regulating similar rules of the state of North Dakota. One year's credit will be granted for a graduate of a two-year electrical school approved by the state electrical board. The person must have the necessary qualifications, training, and technical knowledge to wire, install, and repair electrical apparatus and equipment in accordance with the standard rules and regulations of the National Electrical Code.

   c. A class B electrician must have at least eighteen months' (3,000 hours total, maximum 2,000 hours per year) experience in farmstead or residential wiring under the supervision of a master or class B electrician. Commercial wiring experience will not be credited for experience toward a class B license. Six months' credit will be granted for a graduate of a two-year electrical school approved by the state electrical board.

2. Apprentice electricians. There are two categories of apprentice electricians.

   a. Apprentice electricians under the joint apprenticeship training committee training program approved by the department of labor.

   b. Electrician trainees who may not be eligible for the joint apprenticeship training committee program and other persons desiring to accumulate a sufficient time and capability in the electrical trade to qualify them to apply for permission to take the examination for the journeyman electrician's license.

Any person may work as an apprentice under a licensed master or class B electrician, but the master or class B electrician may not allow an apprentice to work on any installation without direct constant supervision by a North Dakota licensed electrician working with the apprentice at the worksite. A licensed electrician may supervise not more than three apprentices.

Electrical contractors shall maintain records of all employees who are or will be performing electrical work for that electrical contractor and shall permit the electrical board to examine and copy all such records as required by this section.

Any master or class B electrician who fails or refuses to comply with this section or who fails or refuses to comply or demonstrate compliance with this section at the request of the board or its representative shall subject that person's license to nonrenewal, suspension, or revocation by the board.

3. Master and class B electricians. A master or class B electrician may exercise that person's privileges as a licensed master or class B electrician for no more than one shop or business, and shall comply with provisions as required for contracting with the secretary of state's office as stated in North Dakota Century Code chapter 43-07. A master or class B electrician shall notify the state electrical board office immediately upon changing from contracting status to noncontracting status for the shop or business they represent.

4. Maintenance personnel regularly employed by the owner may maintain or make minor repairs to existing electrical wiring devices and appliances, but are precluded from extending or changing the characteristics of existing circuits, feeders, or other electrical apparatus.

5. Purpose and scope. The purpose of these standards is the practical safeguarding of persons and of buildings and building contents from electrical hazards arising from the use or control of electricity for light, heat, power, and control thereof and of the fire detection system. It covers the electrical conductors and equipment installed within or on public and private buildings and other premises, including yards, carnival and parking lots, railroad right of way and, also the conductors that supply streetlighting, with the associated equipment necessary to its safe operation.

These standards, based on the National Electrical Code, are the result of years of experience and research to meet the demand for uniform standards to govern electrical wiring in North Dakota, and provide basic rules for intelligent and uniform installation and inspection.

All requirements contained herein must be given careful consideration to ensure greatest permanence, convenience, and safety. These standards do not constitute a design specification for any particular installation, nor an instruction manual for untrained persons. Skill and experience are necessary factors for a safe and adequate wiring installation. In cases where these requirements differ or are in conflict with the requirements of the ~~1999~~ 2002 edition, National Electrical Code, the ~~1997~~ 2000 edition, Life

Safety Code NFPA no. 101, and applicable articles in currently adopted state ~~uniform~~ building code pertaining to fire detection, fire alarms, fire communications, and smoke detectors, the more restrictive requirements shall be the minimum.

~~5.~~ 6. Administrative powers and duties. The executive director of the North Dakota state electrical board, under the direction of the board, shall administer laws, rules, and wiring standards of this state, the electrical requirements of the ~~1999~~ 2002 edition, National Electrical Code, the ~~1997~~ 2000 edition, Life Safety Code NFPA no. 101, and applicable articles in currently adopted state ~~uniform~~ building code pertaining to fire detection, fire alarms, fire communications, and smoke detectors. In all cases ~~where~~ when any action is taken by the executive director to enforce the provisions of any sections contained in these electrical regulations, the ~~1999~~ 2002 edition, National Electrical Code, and the ~~1997~~ 2000 edition, Life Safety Code NFPA no. 101, such acts must be done in the name of and on behalf of the state.

The electrical regulations of these standards, the ~~1999~~ 2002 edition, National Electrical Code, and the ~~1997~~ 2000 edition, Life Safety Code NFPA no. 101, may be modified or waived by special permission in particular cases ~~where~~ when such modification or waiver is specifically permitted or in particular cases ~~where~~ when an advancement in the technology of electricity makes such modification or waiver advisable in the best interest of the people of North Dakota. Such "special permission" must, in all cases, be obtained from the executive director in writing prior to the commencement of the work.

Whenever the board is authorized or mandated by law to inspect an electrical installation, the inspector has authority to enter upon land for the purpose of conducting the inspection. Except in emergency circumstances, the inspector shall request permission from the property owner or agent prior to entering a dwelling, other building, or other place so enclosed as manifestly to exclude intruders. If the landowner refuses to give permission, the board may request the district court of the district containing the property for an order authorizing the inspector to enter the property to conduct the inspection. Emergency circumstances include situations presenting imminent danger to health, safety, or property.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-03. General requirements. Electrical installations must be planned to provide adequate capacity for the load.

1. Wiring systems shall have conductors of sufficient capacity to furnish each outlet without excessive line loss or voltage drop. The voltage drop may not exceed five percent at the farthest outlet of power, heating and lighting loads, or combinations of such loads. (See appendix for example.)

2. All wiring materials must be listed by ~~underwriters' laboratories, incorporated, or other accepted~~ approved testing laboratories to safeguard life and property. It is the duty of the electrical installer to secure permission from the executive director to use materials, devices, and methods of installation not specifically covered by these standards. Equipment not approved under a testing laboratory category may be evaluated by a registered professional engineer on state-accepted evaluation forms.

3. All installations must be made in a workmanlike manner with special attention paid to the mechanical execution of work. All conductors must be rigidly supported and all fittings securely fastened.

4. When wiring public school buildings, approval must be received from the department of public instruction and the state electrical board.

5. Overhead conductors may not cross over water wells or known sites where water wells may be drilled. A minimum distance of twenty feet [6.10 meters] in all directions must be maintained for overhead conductors.

6. ~~I-type and E-1 and E-2 type occupancies as defined in the Uniform Building Code, 1997 edition, to include~~ All hospitals, nursing homes, ~~basic care facilities,~~ and ~~all~~ related patient care areas along with dormitories designed to house more than sixteen people must be wired in metal raceway. Portable cleaning equipment receptacle outlets must be installed in corridors and located so that no point in the corridor along the floorline, measured horizontally, is more than twenty-five feet [7.62 meters] from an outlet. Spacing of receptacle outlets for dormitories and assisted living must be in conformity with section 210-60, ~~1999~~ 2002 edition, National Electrical Code.

7. In the wiring of nursing homes and hospitals, reference must be made to the state department of health for special requirements pertaining to operating rooms, delivery rooms, and emergency lighting.

8. Aluminum conductors in sizes smaller than no. 6 may not be used. Aluminum conductors installed and all corresponding materials must be ~~underwriters'~~ approved by testing laboratories ~~listed or other state recognized testing laboratories~~.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-04. Places of assembly. This section covers all buildings, structures, or portions of buildings designed or intended for the assembly of one hundred or more persons.

Places of assembly include: assembly halls, auditoriums, including auditoriums in schools; mercantile, business, and other occupancies; exhibition halls; armories; dining facilities, including restaurants; church chapels; dancehalls; mortuary chapels; museums; skating rinks; gymnasiums and multipurpose rooms; bowling lanes; poolrooms; clubrooms; places of awaiting transportation; courtrooms; drinking establishments; and conference rooms.

Occupancy of any room or space for assembly purposes by less than one hundred persons in a building of other occupancy, and incidental to such other occupancy, must be classed as part of the other occupancy and subject to the applicable provisions.

When such building structures or portions thereof contain a projection booth or stage platform or area for the presentation of theatrical or musical production, either fixed or portable, the wiring for that area must comply with all applicable provisions of article 520, ~~1999~~ 2002 edition, National Electrical Code.

(For methods of determining population capacity, see occupant load value table, section 24-02-01-16.)

1. **Hazardous (classified) locations.** Hazardous areas located in any assemblage occupancy must be installed in accordance with article 500, ~~1999~~ 2002 edition, National Electrical Code, hazardous locations.

2. **Wiring methods.** The fixed wiring method including fire alarms must be metal raceway (and metal boxes) or nonmetallic raceway encased in not less than two inches [5.08 centimeters] of concrete.

   Exception 1: As provided in article 640, ~~1999~~ 2002 edition, National Electrical Code, sound reproduction and similar equipment; in article 800, ~~1999~~ 2002 edition, National Electrical Code, communication circuits~~;~~; and in article 725, ~~1999~~ 2002 edition, National Electrical Code, for class 1, class 2, and class 3 remote control and signaling circuits.

   Exception 2: Listed two-hour fire-rated cables as permitted in article 695-3c and article 700-9, ~~1999~~ 2002 edition, National Electrical Code.

Adjacent areas separated by a fire barrier ~~must~~ may be considered a separate building and may be wired in any approved wiring method in chapter 3 of the 2002 edition, National Electrical Code. For the purpose of this section, a fire barrier is defined as a continuous assembly, vertical or horizontal, in accordance with current state-adopted ~~uniform~~ building code. In no case may it be less than two-hour fire-rated.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-05. Hazardous locations.

1. Hazardous locations must be wired in accordance with articles 500-516. For classifications of oilfield installations refer to RP 500, Classification of Locations for Electrical Installations at Petroleum Facilities, ~~first~~ second edition, ~~June 1, 1991~~ November 1997.

2. Electrical wiring in grain elevators must conform with code requirements, class II, division 1, under article 500, ~~1999~~ 2002 edition, National Electrical Code. All enclosures and electrical equipment mounted in rooms containing grinders, cleaners, roller mills, hoppers, open conveyors or spouts, mixers, and other dust-producing machinery must be ~~labeled and~~ approved for class II, division 1 location, including motor controllers of the type in which starting and running contractors are oil immersed. General purpose enclosures may only be installed in dust-free locations.

   a. Surge arrestors must be provided for all services in grain elevators.

   b. Hot bearing or other similar detection systems must be installed in accordance with articles 500-516, ~~1999~~ 2002 edition, National Electrical Code.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-06. Grounding. Grounding must conform to article 250, ~~1999~~ 2002 edition, National Electrical Code.

1. At motor connections, a bonding jumper sized in accordance with table 250-122, ~~1999~~ 2002 edition, National Electrical

Code, must be provided around all flexible conduit in sizes one-half inch [12.70 millimeters] and larger. The bonding jumper is not required where a separate grounding conductor is included.

2. Grounding of metal lighting standards. Definition of lighting standard is a pole exceeding twelve feet [3.66 meters] in height measured from the bottom of the base or from the intended grade level of poles.

   a. Circuits run in nonmetallic conduit or buried directly in the ground: the metal lighting standard must be grounded by use of an equipment grounding conductor, not the neutral conductor. This equipment grounding conductor must be run continuously throughout the system and properly bonded to each standard by use of lugs.

   b. The metal lighting standard must be connected to a one-half inch [12.70 millimeters] by ten-foot [3.05-meter] copperweld ground rod by the means of a bonding jumper. The ten-foot [3.05-meter] ground rod must be driven in the center of the metal standard base and project slightly above the base. Both ground rod and equipment grounding conductor must be connected to the metal standards. The bonding jumper must be in accordance with ~~1999~~ 2002 edition, National Electrical Code, and in no case smaller than no. 8 copper or no. 6 aluminum.

3. The grounding electrode conductor must be connected to the grounded service conductor in the enclosure for the service disconnect.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-07. Branch circuits and feeders. Branch circuits and feeders must comply with articles 210 and 215, ~~1999~~ 2002 edition, National Electrical Code.

1. The total connected load must be divided as evenly as practicable, between the two ungrounded conductors of a three-wire system and three conductors of a four-wire wye system.

2. A separate circuit with disconnect must be provided for the purpose of operating or controlling electrical equipment on heating units. Wiring requirements for fixed electrical space heating equipment is provided under article 424, ~~1999~~ 2002 edition, National Electrical Code.

3. Dwelling occupancies having built-in baking or cooking units installed separately must have an individual disconnect and overcurrent protective device. Conductors supplying these units must have a carrying capacity according to nameplate rating.

4. A minimum of six 20-amp small appliance branch circuits must be installed for counter receptacles in kitchens that may be used to serve public gatherings at schools, churches, lodges, and similar buildings. Any island counter in public gatherings must have at least one receptacle.

5. Dwelling occupancies. A minimum of three 20-amp small appliance branch circuits must be installed to supply receptacle outlets in kitchen, pantry, dining room, and breakfast room. These circuits may not supply other outlets and must have conductors not smaller than no. 12. Two of these circuits must supply receptacle outlets on or near work counter area and so arranged that adjacent receptacles are not on the same circuit. ~~(See appendix for examples.)~~

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-08. Services. Electrical services must comply with article 230, ~~1999~~ 2002 edition, National Electrical Code.

1. Perpendicular mast used for support of a service must not be less than two-inch [5.08-centimeter] galvanized rigid steel conduit or intermediate metal conduit, fitted with storm collar flashing.

2. To eliminate moisture condensation, a suitable, pliable compound must be installed to prevent circulation of air from a warmer to a colder section of the raceway (see section 300-7, ~~1999~~ 2002 edition, National Electrical Code).

3. ~~Switch location.--Overcurrent devices~~ Lighting, appliance, and power panel boards may not be located in bathrooms, clothes closets, stairways, or crawl space.

   a. Outside switch location. In no case may the equipment be mounted lower than two feet [.6096 ~~meters~~ meter] above grade level.

   b. All services in one-family and two-family dwellings must be located in a single accessible location.

Exception: Special permission may be granted by the electrical inspector for a second service location to be added where there is no available space for the service equipment. The second service location must be installed in accordance with article 230-2, ~~1999~~ 2002 edition, National Electrical Code.

4. Rating of service switch. Any new or old single-family dwelling where the main house service panel is altered, the dwelling is moved, or where the dwelling is rewired, a minimum one hundred ampere service-rated panel must be installed.

   a. A one hundred ampere service must be installed using ungrounded conductors rated at one hundred amperes. The panel must contain provisions for a minimum of twenty full-sized branch circuit spaces.

   b. A two hundred ampere or larger ~~service~~ main house panel must be installed using ungrounded conductors ~~rated at two hundred amperes~~ sized for the proper ampacity. The panel or panels must contain provisions for a minimum of forty full-sized branch circuit spaces.

   c. Service calculation for electric heating loads must be sized to one hundred twenty-five percent of the full load rating.

5. Underground services. Underground service must comply with article 230, part C, ~~1999~~ 2002 edition, National Electrical Code. Cables or individual conductors on outside of buildings or poles must be protected where subject to mechanical injury. Where rigid metal conduit is used, a bushing must be used on both ends. Sufficient slack conductor must be left to allow for ground settling next to foundations. Past experience indicates that the ground next to a foundation has settled as much as three feet [.914 ~~meters~~ meter]. ~~Where conduit is used on a pole to protect such conductors, it must comply with the 1999 edition of the National Electrical Code. Metal conduit protecting underground conductors on a pole or building must be grounded.~~

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-09. Overcurrent protection. Overcurrent protection must comply with article 240, ~~1999~~ 2002 edition, National Electrical Code. Exterior overcurrent devices must be located at a height of no less than two feet [.6096 ~~meters~~ meter] above grade level to the bottom of the enclosure.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-10. Wiring methods.

1. Agricultural buildings. This section covers all buildings housing livestock, poultry, and other areas of similar or like nature. All electrical panel boards, wiring devices, and equipment must be installed in accordance with the provisions of article 547, ~~1999~~ 2002 edition, National Electrical Code.

2. Electric metallic tubing may not be used in concrete below grade, in concrete slab or masonry in direct contact with earth. ~~(~~A vapor barrier, if used, will have no effect on the requirements of the section.~~)~~ Electric metallic tubing may not be embedded in earth or fill.

3. Aluminum conduit may not be installed in contact with earth or embedded in concrete.

4. The installation of rigid nonmetallic conduit must comply with the provision of article 347, ~~1999~~ 2002 edition, National Electrical Code. Expansion fittings for rigid nonmetallic conduit must be provided to compensate for thermal expansion and contraction in accordance with section 347-9, ~~1999~~ 2002 edition, National Electrical Code. When installed outdoors and above grade, one hundred forty degrees Fahrenheit [60 degrees Celsius] must be considered the minimum change in degrees.

5. Fertilizer rooms, meatpacking plants, salt processing plants, and similar locations are judged to be occupancies where severe corrosive conditions are likely to be present. It is recommended that nonmetallic conduit with nonmetallic boxes and fittings be used as the wiring method for such occupancies. Ferrous and nonferrous metal raceways may be used providing the raceway, boxes, and fittings are properly protected against corrosion.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-10.1. Electrical equipment submerged in water. Electrical wiring and equipment exposed to water damage must comply with the following:

1. All breaker panel boards, breakers, fuses, disconnect switches, controllers, receptacles, switches, light fixtures, and electric heaters that have been submerged must be replaced.

2.--All or all electrical equipment, switchgear, motor control centers, boilers and boiler controls, electric motors, transformers, and other similar equipment such as appliances, water heaters, dishwashers, ovens, and ranges that have been submerged must be reconditioned by the original manufacturer or by its approved representative or replaced.

3. 2. Electrical wiring may require replacement depending on the type of wire or cable and what application it was listed for.

4. 3. Splices and terminations must be checked to make sure they comply with article 110-14, 1999 2002 edition, National Electrical Code.

Other recommendations can be found in "Guidelines for Handling Water Damaged Electrical Equipment" published by the national electrical manufacturers association (NEMA).

History: Effective January 1, 1999; amended effective April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-14.1. Mobile home parks and recreational vehicle parks. Mobile homes, manufactured homes, and mobile home parks must comply with article 550, 2002 edition, of the National Electrical Code.

Service equipment may be installed on manufactured homes as required in 550-23(b) if the following requirements are met:

1. The mobile home is located on property owned by homeowner and not in mobile home park.

2. The mobile home is secured to a permanent foundation that complies with currently adopted state building code.

History: Effective April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-16. Marking of means of egress, illumination of means of egress, and emergency lighting. The purpose of this section is to provide exit and emergency lighting requirements in accordance with Life Safety Code, NFPA 101, 1997 2000 edition, in simple and condensed form. For occupancies or items not covered in this condensed version, refer to NFPA 101, 1997 2000 edition, for complete details. In the wiring of institutional occupancies, governmental agencies may use other codes,

which may be more stringent, especially ~~where~~ when federal funds are involved.

1. Marking of means of egress. All required exits and access to exits must be marked by readily visible signs with letters not less than six inches [15.24 centimeters] high and arrows indicating direction to exits. Every sign must be suitably illuminated. See section 5-10.3, Life Safety Code, NFPA 101, ~~1997~~ 2000 edition.

2. Illumination of means of egress. Illumination of means of egress must provide continuous, dependable, illumination of not less than one foot-candle at floor level for all areas such as corridors, stairways, and exit doorway, providing a lighted path of travel to the outside of the building and public way during all times that the means of egress is available for use. Illumination must be from a source of reasonable assured reliability and may be supplied from normal lighting circuits or special circuits with switching controlled by authorized personnel. Illumination required for exit marking may also serve for illumination of means of egress and must be so arranged that failure of a single unit such as burning out of a single bulb will not leave any area in darkness.

3. Emergency lighting. Emergency lighting systems must be so arranged to provide the required illumination automatically in event of any interruption or failure of the normal power supply. An acceptable alternate source of power may be an electric generator or approved battery. In occupancies where emergency lighting is required, the circuits supplying exit marking and illumination of means of egress must be supplied by the emergency system. Other areas of the facilities only requiring exit marking and illumination of means of egress may be supplied by the normal source.

4. Classification of occupancy ~~(~~based on chapter 4, Life Safety Code, NFPA 101, ~~1997~~ 2000 edition~~)~~.

   Note: Check with local building official to determine occupancy and occupancy load.

   Assembly. Assembly occupancies include all buildings or portions of buildings used for gathering together fifty or more persons for such purposes as deliberation, worship, entertainment, eating, drinking, amusement, or awaiting transportation. Assembly occupancies also include special amusement buildings regardless of occupant load.

   Assembly occupancies include the following:

Armories	Mortuary chapels
Assembly halls	Motion picture theaters

Auditoriums
Bowling lanes
Clubrooms
College and university classrooms, fifty persons and over
Conference rooms
Courtrooms
Dancehalls
Drinking establishments
Exhibition halls
Gymnasiums
Libraries
Museums
Passenger stations and terminals of air, surface, underground, and marine public transportation facilities
Places of religious worship
Poolrooms
Recreation piers
Restaurants
Skating rinks
Theaters

Occupancy of any room or space for assembly purposes by fewer than fifty persons in a building or other occupancy and incidental to such other occupancy must be classified as part of the other occupancy and must be subject to the provisions applicable thereto.

Educational. Educational occupancies include all buildings or portions of buildings used for educational purposes through the twelfth grade by six or more persons for four or more hours per day or more than twelve hours per week.

Educational occupancies include the following:

Academies
Kindergartens
Nursery schools
Schools

Other occupancies associated with educational institutions must be in accordance with the appropriate part of Life Safety Code, NFPA 101, ~~1997~~ 2000 edition.

In cases ~~where~~ when instruction is incidental to some other occupancy, the section of Life Safety Code, NFPA 101, ~~1997~~ 2000 edition, governing such other occupancy applies. For example:

Classrooms under fifty persons - business occupancy
Classrooms fifty persons and over - assembly
Instructional building - business occupancy
Laboratories, instructional - business occupancy
Laboratories, noninstructional - industrial

Health care. Health care occupancies are those used for purposes such as medical or other treatment or care of persons suffering from physical or mental illness, disease, or infirmity and for the care of infants, convalescents, or infirm aged persons. Health care occupancies provide sleeping facilities for four or more occupants and are occupied by persons who are mostly incapable of self-preservation because

of age, physical or mental disability, or because of security measures not under the occupants' control.

Health care occupancies include the following:

Hospitals
Limited care facilities
Nursing homes

Health care occupancies also include ambulatory health care centers.

Detention and correctional. Detention and correctional occupancies are used to house individuals under varied degrees of restraint or security and are occupied by persons who are mostly incapable of self-preservation because of security measures not under the occupants' control.

Detention and correctional occupancies include the following:

Adult and juvenile substance abuse centers
Adult and juvenile work camps
Adult community residential centers
Adult correctional institutions
Adult local detention facilities
Juvenile community residential centers
Juvenile detention facilities
Juvenile training schools

Residential. Residential occupancies are those occupancies in which sleeping accommodations are provided for normal residential purposes and include all buildings designed to provide sleeping accommodations.

Exception. Those classified under health care or detention and correctional occupancies.

Residential occupancies are treated separately in Life Safety Code, NFPA 101, ~~1997~~ 2000 edition, in the following groups:

Hotels, motels, and dormitories
Apartment buildings
Lodging or rooming houses
One-family and two-family dwellings
Board and care facilities

Mercantile. Mercantile occupancies include ~~store~~ stores, markets, and other rooms, buildings, or structures for the display and sale of merchandise.

Mercantile occupancies include the following:

Auction rooms
Department stores
Shopping centers
Supermarkets

Drugstores

Office, storage, and service facilities incidental to the sale of merchandise and located in the same building are included with mercantile occupancy.

Business. Business occupancies are those used for the transaction of business (other than those covered under mercantile), for the keeping of accounts and records, and for similar purposes.

Business occupancies include the following:

- Air traffic control towers (ATCTs)
- City halls
- College and university instructional buildings, classrooms under fifty persons, and instructional laboratories
- Courthouses
- Dentists' offices
- Doctors' offices
- General offices
- Outpatient clinics, ambulatory
- Townhalls

Doctors' and dentists' offices are included unless of such character as to be classified as ambulatory health care occupancies.

Industrial. Industrial occupancies include factories making products of all kinds and properties devoted to operations such as processing, assembling, mixing, packaging, finishing or decorating, and repairing.

Industrial occupancies include the following:

- Drycleaning plants
- Factories of all kinds
- Food processing plants
- Gas plants
- Hangars (for servicing or maintenance)
- Laundries
- Power plants
- Pumping stations
- Refineries
- Sawmills
- Telephone exchanges

In evaluating the appropriate classification of laboratories, the authority having jurisdiction should determine each case individually based on the extent and nature of the associated hazards. Some laboratories may be classified as occupancies other than industrial, for example, a physical therapy laboratory or a computer laboratory.

Storage. Storage occupancies include all buildings or structures utilized primarily for the storage or sheltering of goods, merchandise, products, vehicles, or animals.

Storage occupancies include the following:

Barns
Bulk oil storage
Cold storage
Freight terminals
Grain elevators
Hangars (for storage only)
Parking structures
Stables
Truck and marine terminals
Warehouses

Storage occupancies are characterized by the presence of relatively small numbers of persons in proportion to the area. Any new use that increases the number of occupants to a figure comparable with other classes of occupancy changes the classification of the building to that of the new use.

Day care. Day care occupancies include all buildings or portions of buildings in which four or more clients receive care, maintenance, and supervision, by other than their relatives or legal guardians, for less than twenty-four hours per day.

Day care occupancies include the following:

Child day care occupancies
Adult day care occupancies, except where part of a health care occupancy
Nursery schools
Day care homes
Kindergarten classes that are incidental to a child day care occupancy

In cases where when public schools offer only half-day kindergarten programs, many child day care occupancies offer state-approved kindergarten classes for children who require full day care. As these classes are normally incidental to the day care occupancy, the requirements of the day care occupancy should be followed.

Mixed occupancies. Where two or more classes of occupancy occur in the same building or structure and are intermingled so that separate safeguards are impracticable, means of egress facilities, construction, protection, and other safeguards must comply with the most restrictive life safety requirements of the occupancies involved.

5. Occupant load value table.

Occupancy	Square Feet Per Person
Assembly	15 net *
Areas of concentrated use without fixed seating	7 net
Waiting space	3 net
Bleachers, pews, and similar bench-type seating	Note 1

Fixed seating	Note 2
Kitchens	100 gross**
Libraries:	
In stack areas	100 gross
In reading rooms	50 net
Swimming pools:	
Water surface	50 gross
Pool decks	30 gross
Stages	15 net
Educational occupancies	
Classroom area	20 net
Shops, laboratories, and similar vocational areas	50 net
Health care	
Sleeping departments	120 gross
Inpatient departments	240 gross
Detention and correctional	
Maximum number of persons intended to occupy that floor, but not less than	120 gross
Residential	
Hotels, motels, dormitories, apartment buildings: Maximum probable population, but not less than	200 gross
Lodging or roominghouses: Sleeping accommodations for a total of sixteen or fewer persons on either a transient or permanent basis, with or without meals, but without separate cooking facilities or individual occupants	No requirements
One-family and two-family dwellings	No requirements
Residential board and care occupancies	Note 3
Mercantile (including malls)	
Street level and below (sales)	30 gross
Upper floor (sales)	60 gross
Office areas	100 gross
Storage, receiving, or shipping (not open to the general public)	300 gross
Assembly areas	See "Assembly"
Business	
Business purposes	100 gross
Other purposes	Note 4
Industrial	
Maximum number of persons intended to occupy that floor but not less than	100 gross
Storage	
No occupant load factor specified	
Day care	
Maximum number of persons intended to occupy that floor, but not less than	35 net

* Net floor area is the actual occupied area, not including accessory unoccupied areas or thickness of walls.

** Gross floor area is the floor area within the inside perimeter of the outside walls of the building under consideration with no deduction for

hallways, stairs, closets, thickness of interior walls, columns, or other features.

Notes to occupant load table.

Note 1. Bleachers, pews, and similar bench-type seating: one person per eighteen linear inches [45.72 centimeters].

Note 2. Fixed seating. The occupant load of an area having fixed seats must be determined by the number of fixed seats installed. Required aisle space serving the fixed seats may not be used to increase the occupant load.

Note 3. Refer to chapters 22 and 23 of Life Safety Code, NFPA 101, ~~1997~~ 2000 edition.

Note 4. Occupant load factors associated with the use.

6. Building classification table.

x - indicates required
o - indicates not required

Occupancy	Marking of Means Egress	Illumination of Means Egress	Emergency Lighting
Assembly	x	x	x
Educational	x Note 4	x	x
Interior stairs and corridors	x	x	x
Normally occupied spaces	x	x	x Note 6
Flexible and open plan buildings	x	x	x
Interior or windowless portions of buildings	x	x	x
Shops and laboratories	x	x	x
Health care occupancies (Note 1) (for complete details see Article 517 of NEC and NFPA Standard 99)	x	x	x
Detention and correctional	x	x	x
Residential			
Hotels and dormitories	x	x	o
More than twenty-five rooms	x	x	x Note 2
Apartment buildings			
Twelve or less apartments	x	x	o Note 3
More than twelve apartments or greater than three floors	x	x	x Note 3
Residential board and care			
More than sixteen	x	x	x
Mercantile			
Class A - over thirty thousand square feet [2787.09 square meters]	x	x	x

Class B - three thousand to thirty thousand square feet [278.71 square meters to 2787.09 square meters]	x	x	x
Class C - under three thousand square feet [278.71 square meters]	x Note 7	x	o
Malls	x	x	x
Business	x	x	o
Two or more stories above exit discharge	x	x	x
Fifty or more persons above or below level of exit discharge	x	x	x
Three hundred or more persons	x	x	x
All windowless and underground	x	x	x
Industrial	x	x Note 8	x Notes 8 & 9
Storage	x	x Note 10	x Notes 10 & 11
Day care			
Interior stairs and corridors	x	x	x
Normally occupied spaces	x	x	x Note 6
Flexible and open plan buildings	x	x	x
Interior or windowless portions of buildings	x	x	x
Shops and laboratories	x	x	x
Family day care homes (more than three but fewer than seven persons)	o	x	o
Group day care homes (seven to twelve persons)	o	x	o

Special structures (refer to chapter 32, Life Safety Code, NFPA 101, ~~1997~~ 2000 edition.

Mixed occupancies (Note 5).

NOTES:

Note 1. Exception: Power supply for exit and emergency lighting must conform to NFPA 110.

Note 2. Exception: Where each guest room or guest suite has an exit direct to the outside of the building at street or ground level emergency lighting is not required.

Note 3. Exception: Buildings with only one exit need not be provided with exit signs.

Note 4. Exception: Signs are not required in situations where locations of exits are otherwise obvious and familiar to all occupants, such as in small elementary school buildings.

Note 5. Exception: Where the same means of egress serve multiple-use or combined occupancies, exit lighting, exit signs, and emergency lighting must be provided for the occupancy with the most stringent lighting requirements. The occupant load of each type of occupancy must be added to arrive at the total occupant load.

Note 6. Exception: Administrative areas, general classrooms, mechanical rooms, and storage areas.

Note 7. Exception: Where an exit is immediately apparent from all portions of the sales area, the exit marking is not required.

Note 8. Exception: Special purpose industrial occupancies without routine human habitation.

Note 9. Exception: Structures occupied only during daylight hours, with skylights or windows arranged to provide the required level of illumination on all portions of the means of egress during these hours.

Note 10. Exception: Storage occupancies do not require emergency lighting when not normally occupied.

Note 11. Exception: In structures occupied only during daylight hours, with skylights or windows arranged to provide the required level of illumination of all portions of the means of egress during these hours, emergency lighting is not required.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-16.1. Smoke detectors and fire alarm systems requirements for evacuation and life safety. Fire alarms must be installed in accordance with the currently adopted state ~~uniform~~ building code and state fire code.

1. **Smoke detectors.** Dwelling units, congregate residences, and hotel or lodging house guest rooms that are used for sleeping purposes must be provided with smoke detectors. Detectors must be installed in accordance with the approved manufacturer's instructions.

   a. In new construction, required smoke detectors must receive their primary power from the building wiring when such wiring is served from a commercial source and must be equipped with a battery backup. The detector must emit a signal when the batteries are low. Wiring must be permanent and without a disconnecting switch other than those required for overcurrent protection. A detector

must be interconnected so all alarms sound when one is activated. If an existing dwelling unit has an interconnected smoke detector system, the rest of the dwelling unit must be interconnected with the existing smoke detector system.

b. In dwelling units, a detector must be installed in each sleeping room and at a point centrally located in the corridor or area giving access to each separate sleeping area. When the dwelling unit has more than one story and in dwellings with basements, a detector must be installed on each story and in the basement. In dwelling units where a story or basement is split into two or more levels, the smoke detectors must be installed on the upper level, except that when the lower level contains a sleeping area, a detector must be installed on each level. When sleeping rooms are on an upper level, the detector shall be placed at the ceiling of the upper level in close proximity to the stairway. In dwelling units where the ceiling height of a room open to the hallway serving the bedrooms exceeds that of the hallway by twenty-four inches [60.96 centimeters] or more, smoke detectors must be installed in the hallway and in the adjacent room. In vaulted ceilings location of the smoke detector shall follow manufacturer's instructions.

2. **Fire alarm systems.** Apartment houses and hotels must be provided with a manual and automatic fire alarm system in apartment houses three or more stories in height or containing sixteen or more dwelling units, in hotels three or more stories in height or containing twenty or more guest rooms, and in congregate residences three or more stories in height or having an occupant load of twenty or more.

~~The--following~~ A table ~~is-not-a-part-of-the-administrative-code,-but~~ in the appendix is offered as a condensed guide for ~~your~~ convenience. For further information consult the currently adopted state ~~uniform~~ building code and fire code~~:~~.

~~Fire-Alarm-System~~

~~0---NOT-required--------X---required~~

Occupancy	Manual Stations	Smoke Detector	Heat Detector	Flow Switch	Fire Station Alarm
Assembly under three hundred	0	0	0	0	0
Assembly over three hundred	X Note 1	0	0	0	0
Amusement buildings	X	X	0	X	X
Hotel motel					

Nineteen rooms or less	O	X Note 2	O	O	O
Three or more story *	X	X	O	O	O
Hotel motel					
Twenty rooms or more * and congregate residences	X	X Note 2	X	X	O
Commons area					
Hotels motels apartment houses	X	X	X Note 3	Note 5	
Educational					
NDCC section 18 12 16					
Institutional *	X	X	X	X	X
Office High rise	X	X	X	X	
Apartments (see #2 above)	O	X	O	O	O

Industrial Check with the local fire authority or the state fire marshal

Office building Check with local jurisdiction

* Health department rules.

Note 1. Placement of devices shall be at exit on each level.

Note 2. Detectors required in each sleeping room and one detector for each seventy five feet (22.86 meters) of hallway.

Note 3. When automatic sprinklers and flow detectors are installed, they shall be connected to the alarm system. Heat detectors required in mechanical room, laundry room, and storerooms.

Note 4. Institutional includes hospitals, nursing homes, jails, and similar facilities, including any occupancy where movement is restricted.

Note 5. If equipped with sprinkler.

Note 6. Emergency voice alarm and signal.

Note 7. One hundred or more sprinkler heads.

All signaling devices for all occupancies must meet Americans with Disabilities Act (ADA) requirements (check ADA requirements).

Smoke detectors in hotels, motels, and apartments are not to be tied to the central alarm system (alarm in room or apartment only).

Central alarm trouble indicator must be located where it will be heard.

~~Systems with two or more zones must have an annunciator panel located at an entrance approved by the local fire department.~~

~~Cities may have additional or more stringent requirements.~~

~~Be aware the table is the minimum and the owner or designer may ask for more.~~

History: Effective February 1, 1996; amended effective January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-17. Carnivals. This section provides standards for temporary outdoor installations of portable electrical wiring and equipment for carnivals and celebrations consisting of overhead and underground installations for lighting and power to tents, stands, concessions, and amusement rides and shall comply with article 525, ~~1999~~ 2002 edition, National Electrical Code.

1. All temporary outdoor installations must be approved by the electrical inspector before usage.

2. Inspection and fees for outdoor carnivals and concessions. Each outdoor amusement enterprise or carnival operating or intending to operate in North Dakota shall notify the North Dakota State Electrical Board, Box 857, Bismarck, North Dakota 58502-0857, each year of its itinerary and make application for the initial inspection thirty days before the first engagement in the state. Failure to notify the state electrical board may result in the outdoor amusement enterprise or carnival being responsible for expenses incurred for excess time and travel to inspect these installations.

   a. Fees - $10.00 each ride or concession
   $10.00 reinspection fee on each unit, if required
   $40.00 each transformer or generator truck

   b. The fee must be paid to the inspector at the first engagement or inspection. Each ride or concession will be issued a certification of inspection so that "en route" inspection may be recorded by each inspector.

   c. Each ride or concession wired properly will be issued a certification of compliance, serving for an entire carnival season, subject to subsequent inspections.

   d. Each ride or concession having minor code violations will be issued a correction order with instructions to correct the same, before a following engagement, which will require a reinspection with a ten dollar reinspection fee.

e. The electrical inspector is empowered to write a correction order for immediate compliance should the inspector find a condition dangerous to life and property.

History: Amended effective October 1, 1987; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-18. National electrical manufacturers association enclosures. This section provides national electrical manufacturers association standards which apply generally to industrial controls and systems.

1. Type 1 - General purpose - Indoor. Type 1 enclosures are intended for use indoors, primarily to prevent accidental contact of personnel with the enclosed equipment, in areas where unusual service conditions do not exist.

2. Type 2 - Drippproof - Indoor. Type 2 enclosures are intended for use indoors to protect the enclosed equipment against falling noncorrosive liquids and falling dirt. They shall have provision for drainage. If provision is made for the entrance of conduit at the top, it must consist of a conduit hub or the equivalent. When completely and properly installed, these enclosures must prevent the entrance of dripping liquid at a higher level than the lowest live part within the enclosure.

3. Type 3 - Dusttight, raintight, and sleet resistant (ice resistant) - Outdoor. Type 3 enclosures are intended for use outdoors to protect the enclosed equipment against windblown dust and water. They are not sleetproof (iceproof). They must have conduit hubs or equivalent provision for watertight connection at the conduit entrance, mounting means external to the equipment cavity, and provision for locking.

   Type 3R - Rainproof and sleet resistant (ice resistant) - Outdoors. Type 3R enclosures are intended for use outdoors to protect the enclosed equipment against rain and meet the requirements of underwriters' laboratories incorporated, Publication No. UL 508, applying to "Rainproof Enclosures". They are not dustproof, snowproof, nor sleetproof (iceproof). They must have a conduit hub or equivalent provision for watertight connection at the conduit entrance when the conduit enters at a level higher than the lowest live part, provision for locking, and provisions for drainage.

   Type 3S - Dusttight, raintight, and sleetproof (iceproof) - Outdoor. Type 3S enclosures are intended for use outdoors to protect the enclosed equipment against

windblown dust and water and to provide for its operation when the enclosure is covered by external ice or sleet. These enclosures do not protect the enclosed equipment against malfunction resulting from internal icing; where this is a requirement, the apparatus manufacturer should be consulted. These enclosures must have conduit hubs or equivalent provision for watertight connection at the conduit entrance, mounting means external to the equipment cavity, and provision for locking.

4. Type 4 Watertight and dusttight Indoor and outdoor. Type 4 enclosures are intended for use indoors or outdoors to protect the enclosed equipment against splashing water, seepage of water, falling or hose directed water, and severe external condensation. They are sleet resistant but not sleetproof (iceproof). They must have conduit hubs or equivalent provision for watertight connection at the conduit entrance and mounting means external to the equipment cavity.

Type 4X Watertight, dusttight, and corrosion resistant Indoor and outdoor. Type 4X enclosures have the same provisions as Type 4 enclosures and, in addition, are corrosion resistant.

5. Type 5 Superseded by type 12 for control apparatus.

6. Type 6 Submersible, watertight, dusttight, and sleet resistant (ice resistant) Indoor and outdoor. Type 6 enclosures are intended for use indoors or outdoors where occasional submersion is encountered. They shall protect the enclosed equipment against a static head of water of six feet (1.83 meters) for thirty minutes, dust, splashing, or external condensation of noncorrosive liquids, falling or hose directed water, lint, and seepage. They are not sleetproof (iceproof). They must have conduit hubs or equivalent provision for watertight connection at the conduit entrance and mounting means external to the equipment cavity.

7. Type 7, Class I, Division 1, Group A, B, C, or D Indoor hazardous locations Air break equipment. Type 7 enclosures are intended for use indoors, in the atmospheres and locations defined as Class I, Division 1, and Group A, B, C, or D in the National Electrical Code. The letter or letters A, B, C, or D which indicate the gas or vapor atmospheres in the hazardous location must appear as a suffix to the designation "Type 7" to give the complete NEMA designation and correspond to Class I, Division 1, Group A, B, C, or D, respectively, as defined in the National Electrical Code.

8. Type 8, Class I, Division 1, Group A, B, C, or D Indoor hazardous locations Oil Immersed equipment. Type 8 enclosures are intended for use indoors, in the atmospheres and locations defined as Class I, Division 1, and Group A, B,

C,--or--D--in--the--National--Electrical--Code.--The-letter-or letters-A,-B,--C,--or--D--which--indicate--the--gas--or--vapor atmospheres--in-the-hazardous-location-must-appear-as-a-suffix to--the--designation--"Type--8"--to--give--the--complete--NEMA designation-and-correspond-to-Class-I,-Division-1,-Group-A,-B, C,-or-D,-respectively,-as-defined-in-the--National--Electrical Code.

9.--Type--9,--Class--II,--Division--1,--Group--E,-F,-or-G---Indoor hazardous-locations---Air-break-equipment.--Type-9--enclosures are--intended-for-use-indoors-in-the-atmospheres-and-locations defined-as-Class-II,-Division-1,-and-Group-E,-F,-or-G--in--the National--Electrical--Code.---The-letter-or-letters-E,-F,-or-G which-indicate-the-dust-atmospheres-in-the-hazardous--location must--appear--as--a-suffix-to-the-designation-"Type-9"-to-give the-complete-NEMA-designation--and--correspond--to--Class--II, Division--1,-Group-E,-F,-or-G,-respectively,-as-defined-in-the National-Electrical-Code.--These-enclosures-must--prevent--the ingress--of--explosive--amounts-of-hazardous-dust.--If-gaskets are--used,--they--must--be--mechanically--attached--and--of--a noncombustible,-nondeteriorating,-verminproof-material.

10.--Type--10----Mesa.--Type-10-enclosures-must-be-designed-to-meet the---requirements---of---the---mining---enforcement----safety administration,--United-States-department-of-the-interior,-for equipment-to-be-used--in--mines--with--atmospheres--containing methane-or-natural-gas,-with-or-without-coal-dust.

11.--Type-11---Corrosion-resistant-and-drippproof---Oil---Immersed-- Indoor.--Type-11-enclosures-are-corrosion--resistant--and--are intended--for--use--indoors--to-protect-the-enclosed-equipment against--dripping,--seepage,--and--external--condensation---of corrosive--liquids.---In--addition,--they-protect-the-enclosed equipment-against-the-corrosive-effects-of-fumes-and-gases--by providing--for--immersion--of-the-equipment-in-oil.--They-must have-conduit--hubs--or--equivalent--provision--for--watertight connection-at-the-conduit-entrance-and-mounting-means-external to-the-equipment-cavity.

12.--Type--12----Industrial-use---Dusttight-and-driptight---Indoor. Type-12-enclosures-are-intended-for-use-indoors-to-protect-the enclosed--equipment--against--fibers,--flyings,-lint,-dust-and dirt,-and-light-splashing,--seepage,--dripping,--and--external condensation--of--noncorrosive-liquids.--There-may-be-no-holes through-the-enclosure-and--no--conduit--knockouts--or--conduit openings,--except-that-oiltight-or-dusttight-mechanisms-may-be mounted-through-holes-in--the--enclosure--when--provided--with oil-resistant---gaskets.----Doors---must---be---provided--with oil-resistant---gaskets.----In---addition,---enclosures----for combination--controllers--must--have--hinged-doors-which-swing horizontally-and-require-a-tool-to-open.

~~13.--Type-13---Oiltight-and-dusttight---Indoor.--Type-13-enclosures are-intended-for-use-indoors-primarily-to-house-pilot--devices such--as--limit-switches,-foot-switches,-pushbuttons,-selector switches,-pilot-lights,-etc.,-and--to--protect--these--devices against--lint--and--dust,--seepage,-external-condensation,-and spraying--of--water,--oil,--or--coolant.----They---must---have oil-resistant--gaskets--and,-when-intended-for-wall-or-machine mounting,-must-have-mounting-means-external-to--the--equipment cavity.---They--must--have--no--conduit--knockouts-or-unsealed openings-providing-access--into--the--equipment--cavity.---All conduit--openings--must--have--provision--for-oiltight-conduit entry.~~

In nonhazardous locations, the specific enclosure types, their applications, and the environmental conditions they are designed to protect against, when completely and properly installed, are as follows:

Type 1 - Enclosures constructed for indoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment and to provide a degree of protection against falling dirt.

Type 2 - Enclosures constructed for indoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment, to provide a degree of protection against falling dirt, and to provide a degree of protection against dripping and light splashing of liquids.

Type 3 - Enclosures constructed for either indoor or outdoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt, rain, sleet, snow, and windblown dust; and that will be undamaged by the external formation of ice on the enclosure.

Type 3R - Enclosures constructed for either indoor or outdoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt, rain, sleet, and snow; and that will be undamaged by the external formation of ice on the enclosure.

Type 3S - Enclosures constructed for either indoor or outdoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt, rain, sleet, snow, and windblown dust; and in which the external mechanisms remain operable when ice-laden.

Type 4 - Enclosures constructed for either indoor or outdoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt, rain, sleet, snow, windblown dust, splashing water, and hose-directed water; and that will be undamaged by the external formation of ice on the enclosure.

Type 4X - Enclosures constructed for either indoor or outdoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt, rain, sleet, snow, windblown dust, splashing water, hose-directed water, and corrosion; and that will be undamaged by the external formation of ice on the enclosure.

Type 5 - Enclosures constructed for indoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt; against settling airborne dust, lint, fibers, and flyings; and to provide a degree of protection against dripping and light splashing of liquids.

Type 6 - Enclosures constructed for either indoor or outdoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt; against hose-directed water and the entry of water during occasional temporary submersion at a limited depth; and that will be undamaged by the external formation of ice on the enclosure.

Type 6P - Enclosures constructed for either indoor or outdoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt; against hose-directed water and the entry of water during prolonged submersion at a limited depth; and that will be undamaged by the external formation of ice on the enclosure.

Type 12 - Enclosures constructed (without knockouts) for indoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt; against circulating dust, lint, fibers, and flyings; and against dripping and light splashing of liquids.

Type 12K - Enclosures constructed (with knockouts) for indoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt; against circulating dust, lint, fibers, and flyings; and against dripping and light splashing of liquids.

Type 13 - Enclosures constructed for indoor use to provide a degree of protection to personnel against incidental contact with the enclosed equipment; to provide a degree of protection against falling dirt; against circulating dust, lint, fibers, and flyings; and against the spraying, splashing, and seepage of water, oil, and noncorrosive coolants.

History: Amended effective January 1, 1981; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

24-02-01-19. Inspection fees.

1. All electrical installations, including new jobs and additional work on old installations, made in this state, must have an electrical wiring certificate properly executed by the master or class B electrician supervising the installation of electrical wiring. The state electrical board shall prescribe such form, and shall have on hand a supply of such certificates for distribution to master and class B electricians. Such certificate must consist of the original and five copies.

2. Before work commences on any electrical installation where a new entrance is installed, an existing entrance is altered, a building is moved, where a mobile home feeder is installed, or where the cost of the repair work or additional installation exceeds three hundred dollars, the master or class B electrician supervising such installation shall execute an electrical wiring certificate and distribute the various copies as directed. The goldenrod copy of the certificate must be forwarded to the state electrical board or city electrical inspection authority having jurisdiction and the canary copy to the power company before work is commenced. Within fifteen days of completion, use, or occupancy, whichever is foremost, the white and green copies must be forwarded to the office of the state electrical board, along with the proper fee. The pink copy must be retained by the master or class B electrician and the manila copy must be left in, or on the panel or given to the owner. All six copies must contain a description of the work and the legal description of the location. Certificates with job cost of five thousand dollars or less are valid twelve months from the original filing date. The wiring certificate must be submitted with a proper description of work completed and with the proper fee. A new wiring certificate must be filed on all unfinished work.

3. The electric wiring certificates are available from the state electrical board at Bismarck, North Dakota, upon request of any master or class B electrician holding a proper current license from the electrical board. The master or class B electrician shall be held responsible for all certificates issued to that person. A charge of fifteen dollars to cover board costs must be imposed on each lost wiring certificate.

4. A copy of an electrical wiring certificate must be filed with the power supplier before an electrical installation may be energized.

5. Inspection fees shall be as follows:

Job Cost	Inspection Fee
Up to $300.00	$15.00 (minimum fee)

$300.00 to $3,000.00	$15.00 for the first $300.00 plus 2% on balance up to $3,000.00
$3,000.00 to $10,000.00	$69.00 for the first $3,000.00 plus 1.5% on balance up to $10,000.00
$10,000.00 to $15,000.00	$174.00 for the first $10,000.00 plus 1% on balance up to $15,000.00
$15,000.00 to $100,000.00	$224.00 for the first $15,000.00 plus 1/2 of 1% on balance up to $100,000.00
Over $100,000.00	$649.00 for the first $100,000.00 plus 1/4 of 1% on balance

Inspection ~~fee~~ fees must accompany the copies of wiring certificates which must be forwarded to the State Electrical Board, Box 857, Bismarck, North Dakota 58502.

6. Whenever an electrical installation made by or under the supervision of a master or class B electrician is commenced or in use without submitting an electrical wiring certificate, as directed in subsection 2, the certificate may be considered late and the normal inspection fee, as required under this section, is increased in the amount of fifty dollars. In addition, when time and travel ~~is~~ are expended by employees of the board to obtain a late certificate, an investigative fee may be charged to cover the costs incurred. Costs are to be calculated at a rate of fifty dollars per hour and twenty-five cents per mile of travel.

7. Corrections. Whenever a correction order is written and corrections are not completed within the allotted time, there shall be an administration charge of fifty dollars, which must be paid to the board by the master or class B electrician.

8. All reinspections must be paid for by the electrical contractors at a cost of fifty dollars per hour with a minimum charge of one hundred dollars.

9. The electrical inspection fee must be based on the total amount of the electrical contract or total cost to the owner including extras.

10. The following items need not be included in the cost:

    a. Appliances, including dishwashers, heat pumps, air-conditioners, disposals, and similar equipment.

b. Heating, ventilating, and air-conditioning (HVAC) units.

c. Electric motors, PLC, generators; and

d. Industrial machines.

11. The electrical contractor is responsible to collect the proper inspection fee on each installation. When the owner furnishes the material and the electrical contractor furnishes the labor, the owner shall provide the electrical contractor with the total amount expended for electrical materials used in connection with the installation, and the electrical contractor shall then calculate and collect the necessary inspection fee from the owner. Whenever electrical materials are removed from an existing installation and placed at another location, the electrical contractor shall estimate the cost of these materials and include the amount in the job cost for the purpose of calculating the proper inspection fee.

12. The inspection fee for all motor-driven passenger or freight elevators and dumbwaiters installed in North Dakota shall be as follows:

    Elevators and dumbwaiters having horsepower rating up to 5 horsepower - $20.00

    Elevators and dumbwaiters having horsepower rating 5 horsepower through 15 horsepower - $40.00

    Elevators and dumbwaiters having horsepower rating over 15 horsepower - $60.00

    The master electrician (restricted) having supervision of elevator or dumbwaiter installations shall obtain electrical wiring certificates from the state electrical board. The certificate form must be completed, signed by the master electrician (restricted), and forwarded to the state electrical board, Bismarck, North Dakota, with the inspection fee.

13. Electrically driven irrigation machines. ~~Each~~ For each center pivot system, there is a flat fee of fifty dollars. ~~All~~ For all other work, the fee must be based on the cost of electrical materials and labor.

14. Requested inspections. For inspections not covered in this section or special services, the fee must be fifty dollars per hour, including travel time, plus twenty-five cents per mile traveled.

15. For self-wire inspections on wiring done by the owner, the inspection fee must be as stated in this section, except the minimum must be fifty dollars. Owner wiring may be done on

residential and farmstead property occupied by the owner. Certification and inspection ~~is~~ are required as stated in subsection 1. The owner is required to notify the state electrical board or authority having jurisdiction before work commences. Requests for inspection of owner-wired installations must be in writing and must be accompanied by a print or drawing depicting the wiring to be done.

History: Amended effective January 1, 1981; January 1, 1984; October 1, 1987; January 1, 1990; March 1, 1990; January 1, 1993; February 1, 1996; January 1, 1999; April 1, 2002.
General Authority: NDCC 43-09-05
Law Implemented: NDCC 43-09-21, 43-09-22

APPENDIX

Short Cut
At 75° C

Voltage Drop Formulas 167° F

Voltage drop = $\frac{K \times L\ ft. \times I}{C.M.A.}$

or

C.M.A. = $\frac{K \times L\ ft. \times I}{\%\ drop \times voltage}$

L = length in feet, one way

I = load in amps

E = Volts

C.M.A. = circular-mil area

K-factor = 25.8 multiplying factor for copper, 42.4 multiplying factor for aluminum at 75° C.

Percent drop = permissible voltage drop times voltage of circuit as follows:

3% of 208 = 208 x .03 = 6.24 volts

3% of 120 = 120 x .03 = 3.6 volts

3% of 240 = 240 x .03 = 7.2 volts

5% of 240 = 240 x .05 = 12.0 volts

Example:

240 volts, 1,000 ft. distance, 10 ampere load, 5% drop

25.8 x 1,000 = 25,800 x 10 = 258,000

258,000 divided by 26,250 (C.M.A. of No. 6) = 9.8 volts (less than 5%)

258,000 divided by 16,510 (C.M.A. of No. 8) = 15.6 volts (more than 5%)

120 volts, 8 ampere load, 100 ft. distance, 3% drop

25.8 x 100 = 2,580 x 8 = 20,640

20,640 divided by 6,530 (C.M.A. of No. 12) = 3.16 volts (less than 3%)

20,640 divided by 4,107 (C.M.A. of No. 14) = 5.0 volts (more than 3%)

or

25.8 x 8 amps x 100 ft. = 20,640

20,640 divided by 3.6 (volts representing 3%) = 5,733 C.M.A. (No. 12)

For 3-phase circuits, use formula, then multiply the results by .86.

Fire Alarm System Condensed Guide

0 - NOT required X - required

Occupancy	Manual Stations	Smoke Detector	Heat Detector	Flow Switch	Fire Station Alarm
Assembly under three hundred	0	0	0	0	0
Assembly over three hundred	X Note 1	0	0	0	0
Amusement buildings	X	X	0	X	X
Hotel-motel Nineteen rooms or less	0	X Note 2	0	0	0
Three or more story *	X	X	0	0	0
Hotel-motel Twenty rooms or more * and congregate residences	X	X Note 2	X	X	0
Commons area Hotels-motels-apartment houses	X	X	X Note 3	Note 5	
Educational North Dakota Century Code Section 18-12-16					
Institutional *	X	X	X	X	X
Office - High-rise	X	X	X	X	
Apartments (see #2 above)	0	X	0	0	0
Industrial - Check with the local fire authority or the state fire marshal					
Office building - Check with local jurisdiction					

* Health department rules.

Note 1. Placement of devices shall be at exit on each level.

Note 2. Detectors required in each sleeping room and one detector for each seventy-five feet [22.86 meters] of hallway.

Note 3. When automatic sprinklers and flow detectors are installed, they shall be connected to the alarm system. Heat detectors are required in mechanical rooms, laundry rooms, and storerooms.

Note 4. Institutional includes hospitals, nursing homes, jails, and similar facilities, including any occupancy where movement is restricted.

Note 5. If equipped with sprinkler.

Note 6. Emergency voice alarm and signal.

Note 7. One hundred or more sprinkler heads.

All signaling devices for all occupancies must meet Americans with Disabilities Act (ADA) requirements (check ADA requirements).

Smoke detectors in hotels, motels, and apartments are not to be tied to the central alarm system (alarm in room or apartment only).

Central alarm trouble indicator must be located where it will be heard.

Systems with two or more zones must have an annunciator panel located at an entrance approved by the local fire department.

Cities may have additional or more stringent requirements.

Be aware the table is the minimum and the owner or designer may ask for more.

TITLE 38

Highway Patrol

DECEMBER 2001

CHAPTER 38-03-01

38-03-01-02. Adoption of regulations. The following parts of Title 49, Code of Federal Regulations, including amendments, are adopted by reference:

1. Part 107 - Subparts F and G only - Hazardous Materials Program Procedures.

2. Part 171 - General Information, Regulations and Definitions.

2. 3. Part 172 - Hazardous Materials Tables and Hazardous Materials Communications Regulations.

3. 4. Part 173 - Shippers - General Requirements for Shipments and Packagings.

4. 5. Part 177 - Carriage by Public Highway.

5. 6. Part 178 - Shipping Container Specifications.

6. 7. Part 180 - Qualification and Maintenance of Packagings.

History: Effective October 1, 1983; amended effective February 1, 1999; December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 39-21-44

TITLE 45

Insurance, Commissioner of

DECEMBER 2001

CHAPTER 45-02-02

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

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

   a. An 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 application applicant for an agent's insurance producer's license by a partnership must be accompanied by a copy of the agreement business entity must have an active certificate of authority with the North Dakota secretary of state's office.

   c. An application for an agent's license by a corporation must be accompanied by a copy of the articles of incorporation.

   d. An applicant who is licensed as a nonresident agent in this state and seeks to be licensed as a resident agent in another state within the preceding twelve months who moves to this state must provide, with the application, a letter proof of clearance from the state in which the agent insurance producer is currently or was most recently licensed as a resident agent insurance producer. Additionally, the agent must have that state indicate whether the agent was so licensed within the preceding twelve months.

e.--An--application--for--a--corporate--or-partnership-agent's license-must-be-completed-on-a-commissioner-approved-form.

f. d. A--new An application form is not required to add a-new company-unless-adding an additional line of insurance.

g. e. 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** agents' insurance producers' **applications.**

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

b. An applicant for a nonresident agent's 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.

e.--A--new--application--form--is--not--required--to-add-a-new company-unless-adding-an-additional-line-of-insurance.

3. Resident-and-nonresident-brokers'-applications.

a.--An--application--must--be-completed-in-accordance-with-the instruction-sheet-provided-by-the-department-and-submitted on-a-commissioner-approved-application-form.

b.--A--broker's--application--must--be--accompanied-by-written proof-of-compliance-with-the-requirement-that--the--broker have--in--force--a--bond-in-the-penal-sum-of-five-thousand dollars-and-the-appropriate-fee.

c.--An-application-for-a-broker's-license-may-not-be-submitted unless-the-applicant-is-currently-licensed-in--this--state as--an--agent--and--has--had--two--years'-experience-as-an insurance--agent--or--in--comparable--employment--for---an insurance--company,--agency,--or-brokerage-firm-during-the three--years--immediately--next--preceding--the--date---of application.

~~d.--A---broker's---application---must---be--accompanied--by--a certificate-of-an-errors-and-omissions-policy-in-an-amount not-less-than-five-hundred-thousand-dollars.~~

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

~~5.~~ 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~~,--firm,--corporation,--or-partnership~~ holding a license as an agent~~,-broker,~~ insurance producer or surplus lines ~~broker~~ 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 terminated prior to obtaining a consultant's license.

~~c.--No--person-may-apply-for-a-consultant's-license-unless-the applicant-has-had-not-less-than-five-years'-experience--as an--insurance--agent--or--in--comparable-employment-for-an insurance-company,-agency,-or-brokerage-firm,--within--the ten---years---immediately---next--preceding--the--date--of application--in--the--area--of--insurance--in--which---the applicant-intends-to-consult.~~

~~d.--An-application-may-be-submitted-prior-or-subsequent-to-the applicant's-testing-date-and-must-be--accompanied--by--the appropriate-fee.~~

~~6.~~ 5. **Temporary license applications.**

a. An application for a temporary insurance ~~agent's--or broker's~~ producer's license must be submitted in accordance with ~~subdivisions--a,--b,--c,--d,--and--g--of subsection-1,--subsection--2,--and--subsection--3--and--be accompanied-by-the-appropriate-fee~~ 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 ~~agents'~~ 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.
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 ~~take~~ qualify for lines of authority by passing the examination ~~authorized--and--required--by---the department-of-insurance~~ set out in subsection 6.

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

3. ~~The--examination--may-be-taken-prior-or-subsequent-to-the-date an-application-for-the-license-is-submitted-to-the--department at--a--designated--time--and--location-on-a-preregistration-or walk-in-basis,-and-in-compliance-with-all-procedures--required by-the-test-administrator.~~

4. An applicant must present a photo identification card at the test center prior to being admitted for testing. If the applicant does not have a photo identification card, permission to take the test may be specially obtained upon application to the insurance department.

4. At the test center, an applicant must present either proof of completion of prelicensing courses or a waiver from the department.

5. There are two basic parts to each examination:

   a. Part One is the part of the ~~test~~ examination developed as a test of general knowledge for the lines of insurance and there are four such Part Ones:

      (1) 01 Life and annuity

      (2) 02 Accident and health

      (3) 03 Property

      (4) 04 Casualty

   b. Part Two is the part of each ~~test~~ examination which ~~examines~~ tests the applicant's knowledge of North Dakota law.

6. An applicant applying to conduct insurance in the following lines must pass the following ~~tests~~ examinations:

   a. Life and annuity 01 Life and annuity

b.	Accident and health	02 Accident and health
c.	Property	03 Property
d.	Casualty	04 Casualty
e.	Variable life and annuity	01 Life and annuity

7. An examination is valid for as long as a person continuously holds a valid ~~agent's-or-broker's~~ insurance producer's license issued by the North Dakota insurance department and for twelve months following ~~expiration~~ 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.

8. ~~Licensure-tests-for-consultants.~~

   a. An applicant for a consultant license must take and pass the ~~agent's~~ insurance producer's examination for the lines in which the applicant wishes to consult.

   ~~b.--The--applicant--must--comply--with--all-provisions-of-this chapter-regarding-testing-for-an-agent's-license.~~

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 26.1-12, 26.1-14, 26.1-23, 26.1-24, 26.1-27, 26.1-28, 26.1-29

45-02-02-04. Exceptions to examination requirement.

1. ~~Chartered--life--underwriter--and--chartered-property/casualty underwriters-designations.~~

   ~~a.--Holders--of--the-designation-of-chartered-life-underwriter need-take-only-Part-Two-of-the-licensure-test-in-order--to be-qualified-in-the-life-and-annuity-line-of-insurance-and the-products-listed-within-this-line.~~

   ~~b.--Holders--of-the-designation-of-chartered-property/casualty underwriters-need-take-only-Part-Two-of-the-licensure-test in--order--to--be--qualified--to--transact-business-in-the accident-and--health,--property,--and--casualty--lines--of insurance.~~

~~2.--If--an--applicant--previously--held--a-like-license-in-another state-with-which-North-Dakota-has-reciprocal-agreements-within twelve--months--prior--to--the-application-for-license-of-this~~

~~state;-the-applicant-need-take-only-Part-Two-of-the--licensure test-covering-North-Dakota-law-and-administrative-rules.~~

3. Consultants' exemption.

   a. ~~If--an--applicant--holds--a--chartered-life-underwriter-or chartered-property/casualty-underwriters-designation,--the exemptions-in-subsection-1-apply.~~

   ~~b.--Subsection-2-applies-to-consultant-examinations.~~

   c. If an applicant holds an ~~agent's-or-broker's~~ insurance producer's license in North Dakota, the applicant is exempt from the testing requirements for the lines held on that license within the last twelve months; however, the applicant must terminate all other licenses prior to obtaining a consultant's license.

   ~~d.~~ b. Upon application, it may be shown that the educational background or work experience record is an adequate basis to grant an exemption from testing. A narrative must be included with the application.

4. 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 ~~the-appointing~~ an insurer licensed in the line of title insurance. A certification by the ~~appointing~~ insurer that the training has been completed must accompany the application.

5. 3. An applicant for a license to write the following products is exempt from examination requirements:

   a. Baggage insurance sold by a ticket-selling agent of a common carrier for travel with that carrier.

   b. Travel insurance sold by a ticket-selling agent operating within a transportation terminal.

6. 4. 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 ~~life---or~~ including credit life ~~and~~, credit disability, credit property, credit unemployment,

involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile 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.

d. Legal expense, including prepaid legal service.

e. ~~Prepaid--legal--service~~ Personal lines. Personal lines is property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

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 26.1-26-25

45-02-02-05. Effective date of ~~agent~~ insurance producer **license - New line** ~~--New-company-appointment---Renewals~~.

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

2. An ~~agent~~ insurance producer who is adding a new line of insurance may first transact business in that new line effective the ~~same-date-as-the-effective-date-if-the-agent-was obtaining--a--new--license---under---subsection-1~~ 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

45-02-02-06. Appointment ~~procedure---Terminations~~ and termination procedures.

1. ~~The--appointment--of--an--agent--who--is--a-new-agent-shall-be contained-in-the-application-form-submitted-to-the--department of--insurance--to-obtain-that-new-license.~~ 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. ~~The--appointment--of--an--agent--licensed--for--a--new-line-of insurance-shall-be-contained-in-the-application-form-submitted to--the-department.~~ 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. ~~The-appointment-of-an-agent-when-the-agent-is-already-licensed for-the-appropriate-lines-of-insurance-is-accomplished-through an-agreement-or-contract-between-the-company-and-the-agent.--A new-application-form-is-not-required-with-such-an-appointment. However,--for-that-appointment-to-become-effective-the-company must-provide-notice-of-the-appointment-to--the--department--on the--appropriate--appointment--form-and-also-provide-with-that form-the-required-fee.--The-form-must--include--the--following statement:---The--appointing-company-assumes-full-and-complete responsibility-for-the-acts-of-this-agent--without--regard--to any--technical--distinction-between-this-relationship-and-that which-exists-in-law-between-"principal-and--agent"--until--the appointment--process--has-been-completed-and-is-limited-to-the relationship-among-the-proposed-insured,-the--agent,--and--the appointing--company.---Such-appointment-form-must-be-signed-by the--appointing--company--representative--and--mailed--to--the department-on-the-date-the-letter-is-signed.~~ 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. ~~If--a--company--desires--to-limit-the-appointment-to-specified lines-of-insurance-or-insurance-product-types,-such-limitation must--be--clearly--set--out-in-the-applications-or-appointment forms.~~ Failure to timely file appointment or termination notifications may subject an insurer to sanctions under North Dakota Century Code title 26.1.

~~5.--The--fees--for--all--appointments--shall-be-submitted-with-the appointment-forms.~~

~~6.--Notice-of-termination-of-all-appointments-shall-be-provided-by the-company-to-the-department-only-on-an-annual-basis-and-only by--lining-out-the-agent-on-the-renewal-list,-on-or-before-May first-of-each-year-unless-the-agent-was-terminated-for-any--of the--grounds--listed--in--North--Dakota--Century--Code-section~~

~~26.1-26-42,-in-which--case--notification--shall--be--submitted immediately.---Such-immediate-notice-shall-specify-the-grounds for-the-termination.--The-company-is-responsible-for-notifying the-agent-of-the-termination.~~

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 ~~license~~ appointments.

1. On or before March fifteenth of each year, a ~~computerized~~ renewal list of the ~~agents~~ insurance producers appointed by that company, together with an instruction letter, will be furnished by the department to each company.

2. The company shall designate on that list which ~~agents~~ insurance producers it does not wish to renew, and return the list to the department within the timeframe set out in the cover letter.

3. ~~The--renewal--list--shall--be--the--company's--record--of--its appointed-agents.~~

4. The ~~company~~ insurer shall pay the appropriate fee for all appointments which were are renewed, along with the renewal list prior to May first.

History: Effective September 1, 1983; amended effective October 1, 1984; December 1, 2001.
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. ~~The-license-for-any-resident-or nonresident-insurance-agent-who-has-not-had-an-active--appointment--with any--company--for--a--period--of-one-year-or-more-will-be-deemed-to-have lapsed.~~ Repealed effective December 1, 2001.

History: ~~Effective-March-1,-1988.~~
General Authority: ~~NDCC-26.1-26-49~~
Law Implemented: ~~NDCC-26.1-26-31(5)~~

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

~~1.--An--agent--may--in-isolated-situations-share-a-commission-with another-agent-who-has-forwarded-an-insured's-business-to--that agent--where--both--agents--are--licensed--for--that--line--of~~

~~insurance--even--though--the--forwarding--agent--may--not---be appointed-by-the-company-with-which-the-business-is-placed.~~

~~2.--If--such--sharing-of-commission-is-done-on-a-regular-basis,-it will-be-considered-a-violation-of-North--Dakota--Century--Code section-26.1-26-04-by-both-parties-and-disciplinary-action-may be-taken-by-the-department.~~ Repealed effective December 1, 2001.

~~**History:** Effective--September-1,-1983;-amended-effective-April-1,-1996.~~
General Authority: ~~NDCC-26.1-26-49~~
Law Implemented: ~~NDCC-26.1-26-04~~

45-02-02-10. Insurance ~~agent,--insurance--broker,~~ producer **and surplus lines insurance** ~~broker~~ producer **acting as consultant.** Although ~~duly~~ licensed insurance ~~agents,-insurance-brokers,~~ producers or surplus lines insurance ~~brokers~~ producers are exempt from licensing as consultants and are specifically prohibited from concurrently holding a consultant's license and a license as an insurance ~~agent,--or--an insurance-broker,~~ producer or surplus lines insurance ~~broker~~ producer in any line, ~~duly~~ licensed insurance ~~agents,-insurance--brokers,~~ producers or surplus lines insurance ~~brokers~~ producers may perform consulting services in the ordinary course of their businesses. However, if ~~duly~~ licensed insurance ~~agents,-insurance-brokers,~~ producers or surplus lines insurance ~~brokers~~ 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. Agents 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 terminations.

1. An ~~agent--or--a--limited--insurance--representative~~ insurance producer may terminate one's North Dakota insurance license

voluntarily and have a letter of clearance issued by filing a written request with the department.

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

3. The ~~agent~~ insurance producer is responsible for notifying the appointing companies of the termination.

4. A ~~broker,~~ surplus lines ~~broker,~~ insurance producer or consultant ~~license may be terminated administratively and~~ terminate one's license voluntarily and have a letter of clearance issued by the department upon receipt of a written request ~~by the department~~ from the licenseholder.

~~5. A broker's license will be automatically terminated administratively if the underlying agent's license is terminated.~~

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

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

1. **When presumed a violation.** An ~~agent or broker~~ insurance producer is presumed to have violated subsection 8 of North Dakota Century Code section 26.1-26-42 when the ~~agent or broker~~ 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 ~~agent~~ 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 ~~agent~~ 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 ~~life--underwriters~~ association of insurance and financial advisors or the ~~president~~ 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 ~~life--underwriters~~ the North Dakota association of insurance and financial advisors which is located nearest to the residence of the ~~agent--or--broker~~ 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 ~~agents,--brokers,~~ producers **and consultants prohibited - Exceptions.** A licensed insurance ~~agent,--broker,~~ producer or consultant may not solicit or accept a loan from an individual with whom the ~~agent,-broker,~~ insurance producer or consultant came into contact in the course of ~~their~~ the person's insurance business, or sold an insurance policy to, within the past ten years. This does not prohibit a licensed ~~agent,-broker,~~ 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. Agents-and-brokers Insurance producer indebtedness to companies. An ~~agent-or-broker~~ insurance producer who is personally liable and indebted to an insurance company for the payment of commissions, premiums, or other debts incurred in the ~~agent's--or broker's~~ 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 ~~agent--or--broker~~ 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)

45-02-02-16. Notification of criminal convictions and administrative actions - Duty of licensee. ~~Each--licensed--insurance agent,--broker,--or--consultant--shall--notify-the-commissioner-of-their having-been-convicted-of-any-crime-punishable--by--incarceration--within thirty--days--of-the-entering-of-an-order-of-conviction-and-shall-notify the-commissioner-of-any-administrative-action-taken-against-his--license in---another---state---within---thirty--days--of--the--entering--of--the administrative-order-in--that--state.~~ Repealed effective December 1, 2001.

~~**History:** Effective January 1, 1992.~~
~~**General Authority:** NDCC 26.1-26-49~~
~~**Law Implemented:** NDCC 26.1-26-42(5)(12)~~

CHAPTER 45-02-04

45-02-04-02. Definitions. As used in this chapter, unless the context or subject matter otherwise requires:

1. ~~"Agent--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.~~

2. "Commissioner" means the insurance commissioner.

3. 2. "Continuing education" means an accredited educational experience derived from participation in approved lectures, seminars, and correspondence courses in areas related to insurance. This education shall be designed to improve the professional skills of the participant and upgrade the standard of all insurance licensees to better serve the public.

4. 3. "Coordinator" means an individual who is responsible for monitoring insurance education offerings and who serves as the liaison for students, instructors, and the commissioner.

5. 4. "Instructor" means an individual who teaches, lectures, or otherwise instructs an insurance education offering.

6. 5. "Insurance education" means prelicensure education and continuing education.

7. 6. "Insurance lines" for insurance education purposes include life insurance, accident and health insurance, property insurance, and casualty insurance.

7. "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.

8. "License" means the authorization issued to an individual by the insurance commissioner to act as an insurance ~~agent~~ producer.

9. "License applicant" means a person not currently licensed or an ~~agent~~ insurance producer seeking a license for a line or lines of insurance for which the person is not currently licensed.

10. "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).

11. "Prelicensure education" means approved classroom education taken prior to sitting for the state licensing examination and completed within six months of filing the license application.

12. "Sponsor" 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.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-49

45-02-04-03. General rules.

1. **Course requirements.** The 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 continuing education credit:

   a. Prelicensure training.

   b. Prospecting.

   c. Recruiting.

   d. Sales skills and promotions.

   e. Motivation.

   f. Psychology.

   g. Communication skills.

   h. Supportive 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. **Prelicensure course.** A prelicensure course means a classroom program consisting of at least eight credit hours, per line of insurance, with course content including:

   a. For property or casualty insurance, or both:

      (1) North Dakota laws, rules, and regulations relating to property and casualty insurance;

      (2) Insurance and insurance-related concepts;

      (3) Policy provisions;

      (4) Types of policies;

      (5) Perils, exclusions, deductibles, and liability;

      (6) Prospecting and evaluating needs;

      (7) Serving clients; and

      (8) Presentation and acceptance of the policy.

   b. For life and annuity or accident and health insurance, or both:

      (1) North Dakota laws, rules, and regulations relating to life and annuity or accident and health insurance;

      (2) Types of policies and coverages;

      (3) Policy provisions, options, and benefits;

      (4) Completing the application and delivering the policy;

      (5) Taxes, retirement, and other insurance concepts;

      (6) Group insurance; and

      (7) Other provisions affecting insurance benefits.

4. **License applicant responsibility.** All license applicants shall present to the proctor, prior to sitting for insurance licensing examinations, a valid copy of the prelicensure report of compliance.

5. **Licensee responsibility.** Each licensee shall be responsible for maintaining original records of the licensee's 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.

6. **Licensee seeking additional lines.** Effective January 1, 1986, prelicensure education will be required of a current resident ~~agent;---broker;~~ insurance producer or consultant seeking authority in a line of insurance for which ~~he--or--she~~ the person is not currently licensed.

7. **Correspondence course credit.** Credit received by an ~~agent~~ insurance producer for a correspondence course must be based on successful completion of the course as prescribed by the sponsor and approved by the commissioner.

8. **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 continuing education purposes.

9. **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 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 a continuing education course more than once during a reporting period.

10. **Course audit.** The commissioner or an authorized representative reserves the right to audit insurance education offerings with or without notice to the sponsor.

11. **National insurance education independent study.** A licensee who passes a national examination by way of independent study may receive up to fifteen hours of continuing education credit, of which seven and one-half hours will be considered as classroom.

12. **Class attendance.**

   a. No certificate of attendance will be issued to a continuing education participant who is absent for more than ten percent of the classroom hours.

   b. Prelicensure courses must be attended in their entirety.

13. **Examinations.** Course examinations will not be required for insurance education courses, unless required by the sponsor.

14. **Textbooks.** Textbooks are not required for continuing education courses. All course materials must contain accurate and current information relating to the subject matter being taught.

15. **Approval of course offerings.** The commissioner requires sponsors of insurance 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 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. (NOTE: Prelicensure course outlines must include a copy of all textbooks, handouts, etc., excluding Pictorial, R & R Newkirk, and Educational Training Systems, Inc., which are on file at the insurance department.)

        (3) An application for coordinator approval.

        (4) An application for instructor approval.

        (5) A fifty dollar per course filing fee.

    b. A class roster to the commissioner on a commissioner-approved form fifteen days subsequent to completion of all insurance education courses. This requirement may be waived for nationally designated independent study courses.

    c. To course participants subsequent to course offerings:

        (1) A course attendance certificate (10923) and a summary report of compliance (10924) to all students successfully completing an approved continuing education course.

        (2) A prelicensure report of compliance (10925) to all students successfully completing an approved prelicensure course.

    Upon review by the commissioner, sponsors 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 education certificates, correspondence, and advertisements.

16. **Sponsor management responsibility.** Sponsors of insurance education courses are responsible for the actions of their respective instructors and coordinators.

17. **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.

18. **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 education credit."

    b. Advertising must be truthful, clear, and not deceptive or misleading.

19. **Approval of subsequent offerings.** After approval has been granted for the initial offering of a course, approval for subsequent offerings will be granted without the necessity of a new application if a notice of subsequent offering is filed with the commissioner at least fifteen days before the date the course is to be held.

20. **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.

21. **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 sponsor may limit the number of students enrolled in a course.

History: Effective July 1, 1986; amended effective January 1, 2000; December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-49

45-02-04-09. Licensee report of compliance. Reports of compliance for continuing education credit must be submitted with a fee of twenty-five dollars at the end of each two-year period following licensure, except as provided below. All licensed ~~agents~~ resident insurance producers shall submit a compliance report and fee based on the following schedule. Licensed ~~agents~~ resident insurance producers with surnames beginning with:

1. A-K shall report thirty hours or more of approved coursework for the previous two years within thirty days of January first of every odd-numbered year.

2. L-Z shall report thirty hours or more of approved coursework for the previous two years within thirty days of January first of every even-numbered year.

3. A newly licensed ~~agent~~ resident insurance producer shall have the remainder of the calendar year in which initially licensed as a grace period. Beginning January first of the next calendar year, newly licensed ~~agents~~ resident insurance producers must comply with continuing education requirements, reporting the required continuing education credits for each calendar year according to the alphabetized schedule.

4. An ~~agent~~ insurance producer licensed exclusively for the sale of title insurance, travel or baggage insurance, ~~fidelity,~~ surety ~~bonds~~, bail bonds, legal expense insurance, ~~prepaid legal services, group~~ and credit ~~life, or group credit accident and health to cover an indebtedness~~ is exempt from continuing education requirements.

History: Effective July 1, 1986; amended effective November 1, 1990; May 1, 1997; October 1, 1997; January 1, 2000; December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-31.1(1), 26.1-26-31.1(2), 26.1-26-31.4

45-02-04-11. Reciprocity - Proof of good standing and filing of fee. ~~If a nonresident licensee's state of residence has mandatory continuing education requirements substantially similar to the requirements of this state, the commissioner may accept as a report of compliance for continuing education credit, certification of the licensee's compliance in the state of residence. Licensees must submit proof of certification from their state of residence in conformance with section 45-02-04-09 along with the filing fee required in North Dakota Century Code chapter 26.1-26. The determination that another state's continuing education requirements are substantially similar to the requirements of this state shall be solely in the discretion of the commissioner.~~ A nonresident insurance producer who has satisfied the producer's home state's continuing education requirements and is in good standing in the producer's home state shall submit a current letter of certification from the producer's home state and pay a biennial continuation fee of twenty-five dollars as required in North Dakota Century Code section 26.1-26-20. A letter of certification is not required if the home state participates in the national association of insurance commissioners' producer data base and the department can verify the license is in good standing in the insurance producer's home state. The filing of the biennial fee must be in accordance with section 45-02-04-09.

History: Effective January 1, 1992; amended effective December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-31.7

45-02-04-12. Nonresident letter of certification required. ~~Each nonresident licensee shall submit a current letter of certification from their state of residence at the time their continuing education report of compliance is due in this state.~~ Repealed effective December 1, 2001.

History: ~~Effective January 1, 1992.~~
General Authority: ~~NDCC 26.1-26-49~~
Law Implemented: ~~NDCC 26.1-26-31.7~~

45-02-04-13. Penalty. All agents resident insurance producers who are late in filing the required report of continuing education compliance shall pay a penalty of twenty-five dollars in addition to the fee required by North Dakota Century Code section 26.1-26-31.4.

History: Effective January 1, 1992; amended effective December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-31.1, 26.1-26-31.4

45-02-04-14. Cancellation. The license of a nonresident insurance producer who fails to pay the biennial continuation fee of twenty-five dollars within the required timeframe will be canceled.

History: Effective December 1, 2001.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-20

CHAPTER 45-03-07.1

45-03-07.1-04. Credit for reinsurance - Reinsurers maintaining trust funds.

1. Pursuant to North Dakota Century Code section 26.1-31.2-01, the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that, as of the date of the ceding insurer's statutory financial statement, maintains a trust fund in an amount prescribed in this section in a qualified United States financial institution as defined in North Dakota Century Code section 26.1-31.2-03, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported on the national association of insurance commissioners annual statement form by licensed insurers, to enable the commissioner to determine the sufficiency of the trust fund.

2. The following requirements apply to the following categories of assuming insurer:

   a. The trust fund for a single assuming insurer must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to ~~business written in the~~ reinsurance ceded by United States ceding insurers, and in addition, a trusteed surplus of not less than twenty million dollars.

   b. The trust fund for a group, including incorporated and individual unincorporated underwriters, must consist of funds in trust in an amount not less than the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars must be held jointly for the benefit of the United States ceding insurers of any member of the group for all years of account. The incorporated members of the group may not be engaged in any business other than underwriting as a member of the group and must be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. The group shall ~~make available~~ provide to the commissioner annual certifications of the solvency of each underwriter by the group's domiciliary regulator ~~and its~~ or, if a certification is unavailable, a financial statement prepared by each underwriter's independent public accountants ~~of the solvency of each underwriter member of the group~~.

c. The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of ten billion dollars, calculated and reported in substantially the same manner as prescribed by the annual statement instructions and accounting practices and procedures manual of the national association of insurance commissioners, and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, must consist of funds in trust in an amount not less than the assuming insurers' liabilities attributable to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group and, in addition, the group shall maintain a joint trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States ceding insurers of any member of the group. The group shall file a properly executed form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the commissioner annual certifications of each member's solvency by the members' domiciliary regulators and ~~their~~ financial statements of each underwriter member prepared by its independent public accountants ~~of the solvency of each member of the group~~.

3. ~~The trust shall be established in a form approved by the commissioner and complying with North Dakota Century Code section 26.1-31.2-01 and this section.~~ Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that:

a. Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty days after entry of the final order of any court of competent jurisdiction in the United States.

b. Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States policyholders and ceding insurers, their assigns and successors in interest.

c. The trust shall be subject to examination as determined by the commissioner.

d. The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust.

e. No later than February twenty-eighth of each year, the trustees of the trust shall report to the commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding yearend, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December thirty-first.

~~f.--No--amendment--to--the--trust--shall--be--effective-unless reviewed-and-approved-in-advance-by-the-commissioner.~~

4. Credit for reinsurance will not be granted unless the assuming insurer agrees in the trust agreement to the following conditions:

a. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this subsection or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.

b. The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.

c. If the commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States beneficiaries of the trust, the commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.

d. The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

History: Effective October 1, 1995; amended effective December 1, 2001.
General Authority: NDCC 26.1-31.2-04
Law Implemented: NDCC 26.1-31.2

45-03-07.1-06. Reduction from liability for reinsurance ceded to an unauthorized assuming insurer. Pursuant to North Dakota Century Code section 26.1-31.2-02, the commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of North Dakota Century Code section 26.1-31.2-01 in an amount not exceeding the liabilities carried by, or in trust for, the ceding insurer. Such reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in North Dakota Century Code section 26.1-31.2-03. This security may be in the form of any of the following:

1. Cash.

2. Securities listed by the securities valuation office of the national association of insurance commissioners and qualifying as admitted assets.

3. Clean, irrevocable, unconditional, and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in North Dakota Century Code section 26.1-31.2-03, effective no later than December thirty-first of the year for which filing is being made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever occurs first.

~~4. Any other form of security acceptable to the commissioner.~~

An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer under subsections 1, 2, and 3 of section 45-03-07.1-06 shall be allowed only when the requirements of sections 45-03-07.1-07, 45-03-07.1-08, ~~and~~ 45-03-07.1-09, and 45-03-07.1-10 are met.

History: Effective October 1, 1995; amended effective December 1, 2001.
General Authority: NDCC 26.1-31.2-04
Law Implemented: NDCC 26.1-31.2

45-03-07.1-07. Trust agreements qualified under section 45-03-07.1-06.

1. As used in this section:

   a. "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver including conservator, rehabilitator, or liquidator.

   b. "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

   c. "Obligations", as used in subdivision k of subsection 2 means:

      (1) Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

      (2) Reserves for reinsured losses reported and outstanding;

      (3) Reserves for reinsured losses incurred but not reported; and

      (4) Reserves for allocated reinsured loss expenses and unearned premiums.

2. Required conditions:

   a. The trust agreement must be entered into between the beneficiary, the grantor, and a trustee which shall be a qualified United States financial institution as defined in North Dakota Century Code section 26.1-31.2-03.

   b. The trust agreement must create a trust account into which assets must be deposited.

   c. All assets in the trust account must be held by the trustee at the trustee's office in the United States; ~~except--that--a--bank--may--apply--for--the-commissioner's~~

~~permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this section. If the commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in paragraph 1 of subdivision d must also be presentable, as a matter of legal right, at the trustee's principal office in the United States.~~

d. The trust agreement must provide that:

(1) The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

(2) No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

(3) It is not subject to any conditions or qualifications outside of the trust agreement; and

(4) It shall not contain references to any other agreements or documents except as provided for under subdivision k.

e. The trust agreement must be established for the sole benefit of the beneficiary.

f. The trust agreement must require the trustee to:

(1) Receive assets and hold all assets in a safe place;

(2) Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

(3) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

(4) Notify the grantor and the beneficiary within ten days of any deposits to or withdrawals from the trust account;

(5) Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer

absolutely and unequivocably all right, title, and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

(6) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

g. The trust agreement must provide that at least thirty days, but not more than forty-five days, prior to termination of the trust account, written notification of termination must be delivered by the trustee to the beneficiary.

h. The trust agreement must be made subject to and governed by the laws of the state in which the trust is established.

i. The trust agreement must prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

j. The trust agreement must provide that the trustee is liable for its own negligence, willful misconduct, or lack of good faith.

k. Notwithstanding other provisions of this chapter, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, where when it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement, notwithstanding any other conditions in this chapter, may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for the following purposes:

(1) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

(2) To make payment to the assuming insurer of any amounts held in the trust account that exceed one

hundred two percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

(3) Where If the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in North Dakota Century Code section 26.1-31.2-03 apart from its general assets, in trust for such uses and purposes specified in paragraphs 1 and 2 as may remain executory after such withdrawal and for any period after the termination date.

1. Notwithstanding other provisions of this chapter, when a trust agreement is established in conjunction with a reinsurance agreement covering life, annuities, or accident and health risks, if it is customary practice to provide a trust agreement for a specific purpose, such trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

   (1) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies;

   (2) To pay or reimburse the assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement;

   (3) To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; or

   (4) If the ceding insurer has received notification of termination of the trust and the assuming insurer's entire obligations under the specific reinsurance

agreement remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution apart from its general assets, in trust for the uses and purposes specified in paragraphs 1, 2, and 3 as may remain executory after withdrawal and for any period after the termination date.

m. Notwithstanding any other provisions in the trust instrument, if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight or other designated receiver all of the assets of the trust fund. The assets shall be applied in accordance with the priority statutes and laws of the state in which the trust is domiciled applicable to the assets of insurance companies in liquidation. If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy claims of the United States beneficiaries of the trust, the assets or any part of them shall be returned to the trustee for distribution in accordance with the trust agreement.

n. The reinsurance agreement entered into in conjunction with the trust agreement may, but need not, contain the provisions required by paragraph 2 of subdivision a of subsection 4, so long as these required conditions are included in the trust agreement.

3. Permitted conditions:

a. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

b. The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends must be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

c. The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution may be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in paragraph 2 of subdivision a of subsection 4.

d. The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

e. The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary, with written approval by the beneficiary, must be delivered over to the grantor.

4. Additional conditions applicable to reinsurance agreements:

a. A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

(1) Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

(2) Stipulate that assets deposited in the trust account must be valued according to their current fair market value and must consist only of cash, United States legal tender, certificates of deposit issued by a United States bank and payable in United States legal tender, and investments of the types permitted by North Dakota Century Code title 26.1 or any combination of the above, provided ~~that---such investments--are-issued-by-an-institution-that-is-not the-parent,-subsidiary,-or-affiliate--of--either--the grantor--or--the-beneficiary~~ investments in or issued

by an entity controlling, controlled by, or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent of total investments. The reinsurance agreement may further specify the types of investments to be deposited. Where If a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement;

(3) Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or a signature from the assuming insurer or any other entity;

(4) Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

(5) Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver, or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(a) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(b) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

(c) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer liabilities for policies ceded under the agreement. The account must include amounts for policy reserves, claims and losses incurred, including losses incurred but not reported, loss adjustment expenses, and unearned premium reserves; and

(d) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

b. The reinsurance agreement may also contain provisions that:

(1) Give the assuming insurer the right to seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

(a) At the time of withdrawal, the assuming insurer shall replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(b) After withdrawal and transfer, the market value of the trust account is no less than one hundred two percent of the required amount.

The ceding insurer may not unreasonably or arbitrarily withhold its approval.

(2) Provide for:

(a) The return of any amount withdrawn in excess of the actual amounts required for subparagraphs a, b, and c of paragraph 5 of subdivision a, or in the case of subparagraph d of paragraph 5 of subdivision a, any amounts that are subsequently determined not to be due; and

(b) Interest payments, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to ~~subparagraph e of~~ paragraph 5 of subdivision a.

(3) Permit the award by any arbitration panel or court of competent jurisdiction of:

(a) Interest at a rate different from that provided in subparagraph b of paragraph 2;

(b) Court or arbitration costs;

(c) Attorney's fees; and

(d) Any other reasonable expenses.

c. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the department in compliance with this chapter when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction must be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

d. Any trust agreement or underlying reinsurance agreement in existence prior to October 1, 1995, will continue to be acceptable until January 1, 1996, at which time the agreements will have to be in full compliance with this chapter for the trust agreement to be acceptable.

e. The failure of any trust agreement to specifically identify the beneficiary as defined in subsection 1 may not be construed to affect any actions or rights which the commissioner may take or possess pursuant to the provisions of the laws of this state.

History: Effective October 1, 1995; amended effective December 1, 2001.
General Authority: NDCC 26.1-31.2-04
Law Implemented: NDCC 26.1-31.2

45-03-07.1-08. Letters of credit qualified under section 45-03-07.1-06.

1. The letter of credit must be clean, irrevocable, and unconditional and issued or confirmed by a qualified United States financial institution as defined in North Dakota Century Code section 26.1-31.2-03. The letter of credit must contain an issue date and date of expiration and stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit must also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself may not contain reference to any

other agreements, documents, or entities, except as provided in subdivision a of subsection 9. As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court-appointed domiciliary receiver, including conservator, rehabilitator, or liquidator.

2. The heading of the letter of credit may include a boxed section that contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section must be clearly marked to indicate that such information is for internal identification purposes only.

3. The letter of credit must contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

4. The term of the letter of credit must be for at least one year and must contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" must provide for a period of no less than thirty days' notice prior to expiry date or nonrenewal.

5. The letter of credit must state whether it is subject to and governed by the laws of this state or the uniform customs and practice for documentary credits of the international chamber of commerce, publication ~~400~~ 500, and all drafts drawn thereunder must be presentable at an office in the United States of a qualified United States financial institution.

6. If the letter of credit is made subject to the uniform customs and practice for documentary credits of the international chamber of commerce, publication ~~400~~ 500, then the letter of credit must specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in article ~~19~~ 17 of publication ~~400~~ 500 occur.

7. The letter of credit must be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit, pursuant to North Dakota Century Code section 26.1-31.2-03.

8. If the letter of credit is issued by a qualified United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution as

described in subsection 7, then the following additional requirements must be met:

a. The issuing qualified United States financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and

b. The "evergreen clause" must provide for thirty days' notice prior to expiry date for nonrenewal.

9. Reinsurance agreement provisions.

a. The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:

(1) Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover.

(2) Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(a) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

(b) To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;

(c) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the ceding insurer's liabilities for policies ceded under the agreement, such amount shall include amounts for policy reserves, claims and losses incurred, and unearned premium reserves; and

(d) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

(3) All of the provisions of this subdivision should be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(4) If the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and if the assuming insurer's entire obligations under the specific reinsurance remain unliquidated and undischarged ten days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in paragraph 2 of subdivision a as may remain after withdrawal and for any period after the termination date.

b. Nothing contained in subdivision a precludes the ceding insurer and assuming insurer from providing for:

(1) An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to ~~subparagraph e of~~ paragraph 2 of subdivision a; or

(2) The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the case of subparagraph d of paragraph 2 of subdivision a, any amounts that are subsequently determined not to be due.

~~e.--When--a-letter-of-credit-is-obtained-in-conjunction-with-a reinsurance-agreement--covering--risks--other--than--life, annuities,--and--health,-where-it-is-customary-practice-to provide-a-letter-of-credit-for-a--specific--purpose,--then the--reinsurance--agreement,--in--lieu--of--paragraph-2-of subdivision-a,-may-require-that-the-parties-enter--into--a trust---agreement---that--may--be--incorporated--into--the reinsurance-agreement-or-be-a-separate-document.~~

10. A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the department unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. Further, the reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific

obligation under the reinsurance agreement that the letter of credit was intended to secure.

History: Effective October 1, 1995; amended effective December 1, 2001.
General Authority: NDCC 26.1-31.2-04
Law Implemented: NDCC 26.1-31.2

CHAPTER 45-03-07.2

45-03-07.2-02. Accounting requirements.

1. An insurer subject to this chapter, for reinsurance ceded, does not reduce any liability or establish any asset in any financial statement filed with the insurance department if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

   a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer, in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall, using assumptions equal to the applicable statutory reserve basis on the business reinsured. Those expenses include commissions, premium taxes, and direct expenses including billing, valuation, claims, and maintenance expected by the company at the time the business is reinsured.

   b. The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, may not be considered to be such a deprivation of surplus or assets.

   c. The ceding insurer shall reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in-force reinsurance by the ceding insurer must be considered a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where when termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty.

d. At specific points in time scheduled in the agreement, the ceding insurer must terminate or automatically recapture all or part of the reinsurance ceded.

e. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company.

f. The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies for a representative sampling of products or type of business, the risks that are considered to be significant. For products not specifically included, the risks determined to be significant must be consistent with this table.

Risk categories:

(a) Morbidity.

(b) Mortality.

(c) Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

(d) Credit quality. This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

(e) Reinvestment. This is the risk that interest rates will fall and funds reinvested, coupon payments or moneys received upon asset maturity or call, will, therefore, earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

(f) Disintermediation. This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may

have to sell assets at a loss to provide for these withdrawals.

+ - Significant 0 - Insignificant

RISK CATEGORY	a	b	c	d	e	f
Health insurance - other than long-term care or long-term disability	+	0	+	0	0	0
Health insurance - long-term care insurance and long-term disability insurance	+	0	+	+	+	0
Immediate annuities	0	+	0	+	+	0
Single premium deferred annuities	0	0	+	+	+	+
Flexible premium deferred annuities	0	0	+	+	+	+
Guaranteed interest contracts	0	0	0	+	+	+
Other annuity deposit business	0	0	+	+	+	+
Single premium whole life	0	+	+	+	+	+
Traditional non-par permanent	0	+	+	+	+	+
Traditional non-par term	0	+	+	0	0	0
Traditional par permanent	0	+	+	+	+	+
Traditional par term	0	+	+	0	0	0
Adjustable premium permanent	0	+	+	+	+	+
Indeterminate premium permanent	0	+	+	+	+	+
Universal life flexible premium	0	+	+	+	+	+
Universal life fixed premium	0	+	+	+	+	+
Universal life fixed	0	+	+	+	+	+

premium, dump-in premiums allowed

g. (1) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not, other than for the classes of business excepted in paragraph 2, either transfer the underlying assets to the reinsurer or legally segregate the assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner which legally segregates, by contract or contract provision, the underlying assets.

(2) Notwithstanding the requirements of paragraph 1, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding company without segregation of the assets:

(a) Health insurance - Long-term care insurance and long-term disability insurance.

(b) Traditional non-par permanent.

(c) Traditional par permanent.

(d) Adjustable premium permanent.

(e) Indeterminate premium permanent.

(f) Universal life fixed premium, no dump-in premiums allowed.

The associated formula for determining the reserve interest rate adjustment must use a formula that reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = \frac{2\ (I + CG)}{X + Y - I - CG}$$

Where: I is the net investment income.

CG is capital gains less capital losses.

X is the current year cash and invested assets plus investment

income due and accrued less borrowed money.

Y is the same as X but for the prior year.

h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety days of the settlement date.

i. The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

j. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

k. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

2. Notwithstanding subsection 1, an insurer subject to this rule, with the prior approval of the commissioner, may take the reserve credit or establish the asset as the commissioner may deem consistent with North Dakota Century Code title 26.1 or the North Dakota Administrative Code, including actuarial interpretations or standards adopted by the insurance department.

3. a. Agreements entered into after October 1, 1995, which involve the reinsurance of business issued prior to October 1, 1995, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner within thirty days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this chapter and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with this department. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that the work conforms to this chapter.

b. Any increase in surplus net of federal income tax resulting from arrangements described in subdivision a must be identified separately on the insurer's statutory financial statement as a surplus item, aggregate write-ins for gains and losses in surplus in the capital and surplus account, page 4 of the annual statement, and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "reinsurance ceded" line, page 4 of the annual statement as earnings emerge from the business reinsured.

[For example, on the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34 percent tax rate, the net increase in surplus at inception is $13.2 million ($20 million - $6.8 million) which is reported on the "Aggregate write-ins for gains and losses in surplus" line in the Capital and Surplus account. $6.8 million (34 percent of $20 million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations.

At the end of year N+1 the business has earned $4 million. ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million (66 percent of ($4 million - $1 million - $.5 million) up to a maximum of $13.2 million) on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and -$1.65 million on the "Aggregate write-ins for gains and losses in surplus" line of the Capital and Surplus account. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations.]

History: Effective October 1, 1995; amended effective December 1, 2001.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-02-20

CHAPTER 45-03-12

45-03-12-03. Admitted assets. ~~The authorized investments enumerated in North Dakota Century Code chapter 26.1-05 and other assets not prohibited under North Dakota Century Code chapter 26.1-05 nor required to be scheduled as nonadmitted assets in the annual statement, as prescribed by the commissioner, are considered admitted assets, if and to the extent the commissioner finds the asset to be an appropriate investment of policyholder obligation funds. All admitted assets must be valued in accordance with chapter 45-03-15.~~ Repealed effective December 1, 2001.

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~~

45-03-12-04. 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 purposes and procedures of the securities valuation office.

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.
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 45-03-15

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 ~~1999~~ as of March 2001 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance ~~adopted December 1998~~.

History: Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001.
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 ~~1999~~ as of March 2001 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance ~~adopted December 1998~~. 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.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-03, 26.1-03-07, 26.1-03-11.1

CHAPTER 45-05-03

AUTOMOBILE WARRANTY INSURANCE

[Repealed effective December 1, 2001]

CHAPTER 45-06-01.1

45-06-01.1-02. Definitions. For purposes of this chapter:

1. "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.

2. "Bankruptcy" means when a medicare+choice 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.

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

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

5. "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.

6. 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 (medicaid), 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.

7. "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).

8. "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.

9. "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.

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

11. "Medicare+choice plan" means a plan of coverage for health benefits under medicare part C as defined in [refer to definition of medicare+choice plan in ~~section 1859 found in title IV, subtitle A, chapter 1 of Pub. L. 105-33~~ 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+choice medical savings account; and

c. Medicare+choice private fee-for-service plans.

12. "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.

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

14. "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.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-06. Benefit standards for policies or certificates issued or delivered on or after January 1, 1992. 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. 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 amount and copayment percentage factors. 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 issurer 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 of subdivision e of subsection 1 of section 45-06-01.1-06, 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 of subdivision e of subsection 1 of section 45-06-01.1-06; 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.

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.

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 medicaid 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 medicaid 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}, as of the 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 ~~coverages~~ 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 coverage which is substantially equivalent to 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.

2. **Standards for basic** ~~(core)~~ benefits common to all benefit plans. 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 thereof:

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 the medicare part A eligible expenses for hospitalization

paid at the diagnostic-related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuing 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.

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.

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. Preventive medical care benefit: Coverage for the following preventive health services:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from paragraph 2 and patient education to address preventive health care measures.

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

(a) ~~Fecal--occult--blood--test--or--digital~~ Digital rectal examination~~,-or-both~~.

(b) ~~Mammogram.~~

~~(c)~~ Dipstick urinalysis for hematuria, bacteriuria, and proteinauria.

~~(d)~~ (c) Pure tone, air only, hearing screening test, administered or ordered by a physician.

~~(e)~~ (d) Serum cholesterol screening every five years.

~~(f)~~ (e) Thyroid function test.

~~(g)~~ (f) Diabetes screening.

(3) ~~Influenza--vaccine--administered--at--any-appropriate time--during--the--year--and--tetanus~~ Tetanus and diphtheria booster every ten years.

(4) Any other tests or preventive measures determined appropriate by the attending physician.

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.

k. 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. New or innovative benefits should offer uniquely different or significantly expanded coverages.

History: Effective January 1, 1992; amended effective April 1, 1996; July 8, 1997; August 1, 2000; December 1, 2001.
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 ~~apply~~ seek to enroll under the policy ~~not later than sixty-three days after the date of termination of enrollment described~~ during the period specified in subsection 2, and who submit evidence of the date of termination or disenrollment with the application for 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 ~~3~~ 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; or the individual is enrolled under an employee welfare benefit plan that is primary to medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan;

b. The individual is enrolled with a medicare+choice organization under a medicare+choice 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+choice plan:

(1) The organization's or plan's certification ~~under this part~~ has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(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;

~~(3)~~ (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

~~(4)~~ (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 (medicare ~~risk or~~ 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) (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+choice plan under part C of medicare, any eligible organization under a contract under section 1876 (medicare ~~risk or~~ cost), any similar organization operating under ~~an agreement under section 1833(a)(1)(A) (health care prepayment plan)~~ 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 ~~enrolled in medicare part B for benefits~~ eligible for benefits under part A of medicare at age sixty-five ~~or older~~, enrolls in a medicare choice plan under part C of medicare, or in a program of all-inclusive care for the elderly program under section 1894, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.

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 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 such a termination or cessation and ends sixty-three days after the date of the applicable notice;

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 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; and

e. 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 ~~is~~ are a medicare supplement policy that has a benefit package classified as plan A, B, C, or F offered by any issuer.

b. 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 of subsection 3.

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

~~4.~~ 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.
General Authority: NDCC 26.1-36.1-02, 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-14. 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. ~~Where~~ 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 health care financing administration 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. **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 must consist 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 "A" through "J" 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:

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans	[insert letters of plans being offered

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

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments.
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery		At-Home Recovery
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)		Extended Drugs ($3,000 Limit)
				Preventive Care							Preventive Care

***Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year ~~[$1500]~~ [$1530] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are ~~[$1500]~~ [$1530]. 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 does not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.**

* * *

NOTICE [Boldface Type]

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

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

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

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

* * *

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 ~~$[764]~~ $[792]	$0	~~$[764]~~ $[792] (Part A deductible)
61st thru 90th day	All but ~~$[191]~~ $[198] a day	~~$[191]~~ $[198] a day	$0
91st day and after:			
—While using 60 lifetime reserve days		~~$[382]~~ $[396] a day	
—Once lifetime reserve days are used:	All but ~~$[382]~~ $[396] a day		$0
—Additional 365 days		100% of Medicare eligible expenses	
—Beyond the additional 365 days	$0	$0	~~$0~~ $0**
	$0		All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a day	$0	Up to ~~$[95.50]~~ $[99] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

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

PARTS A & B

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

PLAN 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 ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A deductible)	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a day	~~$[191]~~ $[198] a day	$0
91st day and after:			
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days are used:	All but ~~$[382]~~ $[396] a day	~~$[382]~~ $[396] a day	
—Additional 365 days			~~$0~~ $0**
—Beyond the additional 365 days	$0	100% of Medicare eligible expenses	All costs
	$0	$0	
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	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a day	$0	Up to ~~$[95.50]~~ $[99] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

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

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A deductible)	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a day	~~$[191]~~ $[198] a day	$0
91st day and after:			
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days are used:	All but ~~$[382]~~ $[396] a day	~~$[382]~~ $[396] a day	
—Additional 365 days			~~$0~~ $0**
—Beyond the additional 365 days	$0	100% of Medicare eligible expenses	All costs
	$0	$0	
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	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a day	Up to ~~$[95.50]~~ $[99] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

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

PARTS A & B

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

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	~~$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 ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a	deductible)	$0
91st day and after:	day	~~$[191]~~ $[198] a day	
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days	All but ~~$[382]~~ $[396] a	~~$[382]~~ $[396] a day $0	
are used:	day		
—Additional 365 days			~~$0~~ $0**
—Beyond the additional 365		100% of Medicare eligible	
days	$0	expenses	All costs
		$0	
	$0		
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	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a	Up to ~~$[95.50]~~ $[99] a day	$0
101st day and after	day	$0	All costs
	$0		
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN D

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

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

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

(continued)

PLAN D

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a	deductible)	$0
91st day and after:	day	~~$[191]~~ $[198] a day	
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days are used:	All but ~~$[382]~~ $[396] a day	~~$[382]~~ $[396] a day	
—Additional 365 days			~~$0~~ $0**
—Beyond the additional 365 days	$0	100% of Medicare eligible expenses	All costs
	$0	$0	
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	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a	Up to ~~$[95.50]~~ $[99] a day	$0
101st day and after	day	$0	All costs
	$0		
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

** 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 E

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

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

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

PARTS A & B

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

(continued)

PLAN E

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year ~~[$1500]~~ [$1580] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~[$1500]~~ [$1580]. 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 $[1580] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1500]~~ $[1580] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a day	deductible)	$0
91st day and after:		~~$[191]~~ $[198] a day	
While using 60			
Lifetime reserve days	All but ~~$[382]~~ $[396] a day		$0
Once lifetime reserve days		~~$[382]~~ $[396] a day	
Are used:			
Additional 365 days	$0		~~$0~~ $0***
Beyond the additional 365 days	$0	100% of Medicare eligible expenses $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	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a day	Up to ~~$[95.50]~~ $[99] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(continued)

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year ~~[$1500]~~ [$1580] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~[$1500]~~ [$1580]. 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 ~~$[1500]~~ $[1580] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1500]~~ $[1580] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment,			
First $100 of Medicare Approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved amounts*	$0	$100 (Part B deductible	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1500]~~ $[1580] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1500]~~ $[1580] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $100 of Medicare approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1500]~~ $[1580] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1500]~~ $[1580] 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 life-time 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			
First 60 days	All but ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A deductible)	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a day	~~$[191]~~ $[198] a day	$0
91st day and after:			
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days are used:	All but ~~$[382]~~ $[396] a day	~~$[382]~~ $[396] a day	
—Additional 365 days			~~$0~~ $0**
—Beyond the additional 365 days	$0	100% of Medicare eligible expenses	All costs
	$0	$0	
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	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a day	Up to ~~$[95.50]~~ $[99] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN G

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

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

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

(continued)

PLAN G

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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 H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a	deductible)	$0
91st day and after:	day	~~$[191]~~ $[198] a day	
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days are used:	All but ~~$[382]~~ $[396] a day	~~$[382]~~ $[396] a day	
—Additional 365 days			~~$0~~ $0**
—Beyond the additional 365 days	$0	100% of Medicare eligible expenses	All costs
	$0	$0	
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	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a	Up to ~~$[95.50]~~ $[99] a day	$0
101st day and after	day	$0	All costs
	$0		
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN H

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

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

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

PARTS A & B

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

(continued)

PLAN H

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a	deductible)	$0
91st day and after:	day	~~$[191]~~ $[198] a day	
—While using 60 lifetime reserve days			$0
—Once lifetime reserve days are used:	All but ~~$[382]~~ $[396] a day	~~$[382]~~ $[396] a day	
—Additional 365 days			~~$0~~ $0**
—Beyond the additional 365 days	$0	100% of Medicare eligible expenses	All costs
	$0	$0	
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	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a	Up to ~~$[95.50]~~ $[99] a day	$0
101st day and after	day	$0	All costs
	$0		
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN I

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

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

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

(continued)

PLAN I

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN J or HIGH DEDUCTIBLE PLAN J

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year ~~[$1500]~~ [$1580] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are ~~[$1500]~~ [$1580]. 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 prescription drug deductible or the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1500]~~ $[1580] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1500]~~ $[1580] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ~~$[764]~~ $[792]	~~$[764]~~ $[792] (Part A deductible)	$0
61st thru 90th day	All but ~~$[191]~~ $[198] a day	~~$[191]~~ $[198] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but ~~$[382]~~ $[396] a day	~~$[382]~~ $[396] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	~~$0~~ $0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but ~~$[95.50]~~ $[99] a day	Up to ~~$[95.50]~~ $[99] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

(continued)

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

PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

****This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year ~~[$1500]~~ [$1580] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are ~~[$1500]~~ [$1580]. 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 prescription drug deductible or the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1500]~~ $[1580] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1500]~~ $[1580] DEDUCTIBLE,** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1500]~~ $[1580] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1500]~~ $[1580] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY ~~$[1500]~~ $[1580] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO ~~$[1500]~~ $[1580] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar Year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar Year	$0	$0	All costs
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE**			
Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

4. **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.
General Authority: NDCC 26.1-36.1-03, 26.1-36.1-05
Law Implemented: NDCC 26.1-36.1-05

45-06-06.1-14. Special enrollment periods.

1. Employees losing other coverage. A group health plan shall permit an employee who is eligible, but not enrolled, for coverage (or a dependent of the employee if the dependent is eligible, but not enrolled) to enroll for coverage under the terms of the plan if each of the following conditions is met:

   a. The employee or dependent was covered under a group health plan at the time coverage was previously offered to the employee or dependent.

   b. The employee stated in writing at the time coverage was previously offered that coverage under a group health plan was the reason for declining enrollment, but only if the plan required such a statement at the time and provided the employee with notice of the requirement and its consequences.

   c. The employee's or dependent's coverage:

      (1) Was under a Consolidated Omnibus Budget Reconciliation Act continuation provision and the coverage was exhausted; or

      (2) If not under a Consolidated Omnibus Budget Reconciliation Act continuation provision, the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions toward the coverage were terminated.

   d. Under the terms of the plan, the employee requests enrollment not later than thirty days after the date of termination of the coverage or employer contribution.

2. For dependent beneficiaries. A group health plan shall provide for a "dependent special enrollment period" if:

   a. The group health plan makes coverage available with respect to dependents of an employee;

   b. The employee is a participant under the plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

   c. A person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

3. For purposes of this section, a "dependent special enrollment period" is a period of not less than thirty days beginning on the later of:

   a. The date dependent coverage is made available; or

   b. The date of the marriage, birth, adoption, or placement for adoption.

   During the dependent special enrollment period, the dependent or, if not otherwise enrolled, the employee may be enrolled under the plan as a dependent of the employee. In the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent if the spouse is otherwise eligible for coverage.

4. If an employee seeks to enroll a dependent during the first thirty days of the dependent special enrollment period, the coverage of the dependent shall become effective:

   a. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

   b. In the case of a dependent's birth, as of the date of birth; or

   c. In the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02(1)
Law Implemented: NDCC 26.1-36.3

45-09-01-02. Surplus lines insurance ~~broker~~ producer application ~~and bond~~. The insurance commissioner will not issue a surplus lines insurance ~~broker's~~ producer's license until the applicant has met the requirements of North Dakota Century Code ~~sections~~ section 26.1-26-17 ~~and 26.1-26-18~~ and has completed and filed with the commissioner ~~the following:~~

~~1.~~ A completed application for a surplus lines insurance ~~broker~~ producer license. (Appendix I)

~~2. A bond in the penal sum as required by North Dakota Century Code section 26.1-26-18. (Appendix IIa and IIb)~~

History: Effective January 1, 1982; amended effective December 1, 2001.
General Authority: NDCC 26.1-26-49, 26.1-44-09
Law Implemented: NDCC 26.1-26-17, 26.1-26-18

45-09-01-03. ~~Broker~~ Surplus lines insurance producer may conduct search. An insured is permitted to designate the surplus lines ~~broker~~ insurance producer as the insured's agent for purposes of conducting a diligent search to ascertain whether the insured is unable to procure the insurance, indemnity contract, or surety bond desired from a company authorized to do business in this state.

History: Effective January 1, 1982; amended effective December 1, 2001.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-04. Presumption - Diligent search. A presumption that a diligent search has been made by the insured and that the insured was unable to procure the insurance, indemnity contract, or surety bond desired from a company authorized to do business in this state is created when the insurance, contract, or bond is written in one of the categories set out in Appendix ~~III~~ II.

History: Effective January 1, 1982; amended effective December 1, 2001.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-05. Other acceptable lines of coverage. The categories designated in Appendix ~~III~~ II are not to be considered as the only lines of coverage in which unauthorized insurers may be used. Other categories of coverage not listed may be acceptable because of special underwriting considerations, i.e., losses, high exposure, etc. Any exceptions must be fully explained on the surplus lines affidavit and approved by the insurance commissioner.

The securing of advantage as to lower premium rates or as to the terms of the insurance contract do not constitute justification nor are they special underwriting considerations sufficient to allow the surplus lines broker to use an unauthorized company nor lines of coverage other than those designated in Appendix ~~III~~ II.

History: Effective January 1, 1982; amended effective December 1, 2001.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-06. Surplus lines affidavit - Time for filing. Before a surplus lines ~~broker~~ insurance producer procures, affects, or issues any insurance policy, indemnity contract, or surety bond, the ~~broker~~ surplus lines insurance producer shall execute, personally sign, and file an affidavit in acceptable form with the office of the commissioner (Appendix ~~IV~~ III). An affidavit will be deemed filed with the commissioner if it is mailed to the commissioner's office ~~on or before~~ within fifteen days of the effective date of the ~~coverage (policy)~~.

History: Effective January 1, 1982; amended effective December 1, 2001.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-07. Surplus lines affidavit - Limits on availability. The surplus lines affidavits filed with the insurance commissioner will be made available only: to the insured named in the affidavit upon a written request by that insured; to the surplus lines ~~broker~~ insurance producer who executed the affidavit upon written request of that ~~broker~~ surplus lines insurance producer; to duly authorized department personnel; and to any other individual who obtains and files with the commissioner a written waiver and consent form signed by the insured.

History: Effective January 1, 1982; amended effective December 1, 2001.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

45-09-01-08. Additional policy endorsement requirement. In addition to the endorsement required by North Dakota Century Code section 26.1-44-05, every policy issued under North Dakota Century Code chapter 26.1-44 shall be endorsed as follows: THIS POLICY IS ISSUED PURSUANT TO THE NORTH DAKOTA SURPLUS LINES INSURANCE STATUTE UNDER THE SURPLUS LINES INSURANCE PRODUCER LICENSE OF _____. THE INSURER IS A QUALIFIED SURPLUS LINES INSURER, BUT IS NOT OTHERWISE LICENSED BY THE STATE OF NORTH DAKOTA AND DOES NOT PARTICIPATE IN THE NORTH DAKOTA INSURANCE GUARANTY ASSOCIATION.

History: Effective January 1, 1982; amended effective December 1, 2001.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-05

45-09-01-09. Statement of taxable premiums. Surplus lines ~~brokers~~ insurance producers are required by North Dakota Century Code section 26.1-44-06 to file annually a statement of taxable premiums received by that ~~broker~~ surplus lines insurance producer (Appendix ~~V~~ IV).

History: Effective January 1, 1982; amended effective December 1, 2001.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-06

APPENDIX I

~~S-T-A-T-E--O-F--N-O-R-T-H--D-A-K-O-T-A~~

~~Department-of-Insurance~~

~~Bismarck,-ND--58505~~

STATE OF NORTH DAKOTA
DEPARTMENT OF INSURANCE
600 EAST BOULEVARD AVENUE
BISMARCK, ND 58505

APPLICATION FOR SURPLUS LINES ~~BROKER'S~~ INSURANCE PRODUCER'S LICENSE

FOR _____
(Surplus Lines Insurance Producer's Name)

Under the provisions of North Dakota Century Code chapters 26.1-26 and 26.1-44, application is hereby made for a surplus lines broker's license.

The applicant hereby affirms that applicant has read, and is familiar with, the provisions of North Dakota Century Code chapters 26.1-26 and 26.1-44, which govern the placement of insurance with nonadmitted companies, in particular the following requirements:

~~1. Before--license-may-be-issued-there-must-be-deposited-with-the commissioner-of-insurance-a-bond-in-the--amount--of--not--less than-five-thousand-dollars.--The-bond-must-be-in-such-form-and with-such-sureties-as-may-be-acceptable--to--the--commissioner and--must--be-kept-in-force-for-as-long-as-the-license-remains in-effect.~~

~~2.--Each---surplus--lines--broker--shall--file--a--certificate--of insurance-with-the-commissioner,-and-shall-keep-in--force--for as--long--as--the--license--remains--in--effect,-an-errors-and omissions-insurance-policy-in-an-amount--not--less--than--five hundred-thousand-dollars.~~

~~3.~~ Licenses expire annually on April thirtieth, and must be renewed on or before May first if they are to continue uninterruptedly.

~~4.~~ 2. On each risk placed under a surplus lines license, the ~~broker~~ surplus lines insurance producer must make affidavit, in a form acceptable to the insurance commissioner that after reasonable diligent search, the risk cannot be placed with a licensed company. ~~Only--after-the-commissioner-of-insurance concurs-in-the-allegations-contained-in-the-affidavit-can--the broker-proceed-to-place-the-risk-with-the-nonadmitted-company.~~

~~5.~~ 3. Each policy issued under a surplus lines license must be endorsed~~,--"Issued-with-a-nonadmitted--company--under--Broker's License--No.-----"--which--endorsement--must--be--filed-in-and signed-by-the-broker~~ "THIS POLICY IS ISSUED PURSUANT TO THE NORTH DAKOTA SURPLUS LINES INSURANCE STATUTE UNDER THE SURPLUS LINES INSURANCE PRODUCER LICENSE OF . THE INSURER IS A QUALIFIED SURPLUS LINES INSURER, BUT IS NOT OTHERWISE LICENSED BY THE STATE OF NORTH DAKOTA AND DOES NOT PARTICIPATE IN THE NORTH DAKOTA INSURANCE GUARANTY ASSOCIATION." The surplus lines insurance producer shall properly complete the endorsement by typing or printing the surplus lines insurance producer's full name in the space provided and shall sign and date the endorsement.

~~6.~~ 4. The ~~broker~~ surplus lines insurance producer is required to keep a separate record of business transacted under the ~~broker's~~ surplus lines license, and on or before April first of each year, must file with the insurance commissioner a statement for the preceding calendar year ending on December thirty-first, giving the name of the insured to whom each policy has been issued, the name and home office of each company issuing any such policy, the amount of such insurance, the rates charged ~~therefore~~ therefor, the gross premiums charged, ~~and~~ the date and term of the policy, and the amount of premium returned on each policy canceled or not taken, together with such other information and upon such form as required by the insurance commissioner.

~~7.~~ 5. At the time of filing the above statement, the ~~broker~~ surplus lines insurance producer is required to pay the tax (current rate ~~two--and--one-half~~ one and three-fourths percent) on the premium so written on risks or exposures located in this state.

~~8.~~ 6. The ~~broker~~ surplus lines insurance producer is personally responsible for investigating the financial condition of the nonadmitted insurer before placing the insurance therewith. The company must have capital and surplus amounting to at least the amount required of a licensed carrier transacting the same class of business.

~~9.~~ 7. Before a company can be qualified as a nonadmitted surplus lines outlet, it must appoint the insurance commissioner in writing to be its true and lawful attorney, upon whom legal process in any action or ~~proceeding~~ proceeding against it may be served.

~~10.~~ 8. The insurance commissioner may inspect and examine at any time a ~~broker's~~ surplus lines insurance producer's records of business transacted under the surplus lines license.

~~11.~~ 9. The ~~penalties~~ penalty for making a false affidavit ~~include~~ includes revocation of license, and failure to make and file

the required annual statement or to pay the taxes required prior to May first, can result in a fine of twenty-five dollars per day for each day of the delinquency.

~~The applicant is presently licensed to represent the following licensed companies:~~

~~1.~~_____ ~~6.~~_____
~~2.~~_____ ~~7.~~_____
~~3.~~_____ ~~8.~~_____
~~4.~~_____ ~~9.~~_____
~~5.~~_____ ~~10.~~_____

Remittance of ten dollars covering the statutory fee for issuance of the surplus lines license is attached hereto.

_____ ~~SIGNED:~~ _____
~~Date of Application~~ ~~Name~~

_____
~~Address~~

_____ _____
Signature Print Name

_____ _____
Date Business Address

_____
City, State, Zip Code

_____
Telephone Number

APPENDIX-IIa

BOND-NUMBER-----

BOND

KNOW-ALL-MEN-BY-THESE-PRESENTS:

That--we,-----,--as--Principal,--and ----------,-licensed-to-do-a-surety-business-in-the-State--of North--Dakota,--as--Surety,--are-held-and-firmly-bound-unto-the-State-of North-Dakota-for-the-benefit-of--any--aggrieved--party--in--the--sum--of ----------($---------)--for--the--payment-of-which-we-hereby bind--ourselves,--our--heirs,--administrators,--executors,--assigns--and successors--jointly--and-severally-by-these-presents-this----------day of----------,-19---.

THE--CONDITIONS--OF--THIS--OBLIGATION-ARE-SUCH-THAT,-if-the-above-bonded ----------,-presently-applying-for----------license under--North--Dakota--Century--Code--chapter--26.1-26,--shall-faithfully conform-to-and-abide-by-each-and-every-provision-of-that-chapter-and-any other--applicable--laws,--and-shall-pay-to-the-State-of-North-Dakota-for the-benefit-of-any-aggrieved-party-any-and-all-moneys--that--may--become due--or--owing--to--said--aggrieved--party--under--and--by-virtue-of-the provisions-of-said-laws,-then-this-obligation-shall-be--null--and--void; otherwise-to-remain-in-full-force-and-effect.

Provided,--however,-that-this-Suretyship-may-be-terminated-by-the-Surety upon-thirty-days-written-notice-to-the-obligee-and-the-Principal,-or--by the-obligee-upon-notice-in-writing-within-ten-working-days-to-the-Surety specifying-the-date-of-termination.

SIGNED-THIS----------DAY-OF----------,-19----.

Principal

Surety

COUNTERSIGNED:

Attorney-in-fact

North-Dakota-Resident-Agent-or-Broker

1.--INSURANCE-BROKER'S-BOND-must-be-in-the-amount-of-five-thousand dollars-with-an-authorized-corporate-surety--approved--by--the commissioner--and--must--be--kept--in-force-for-as-long-as-the license-remains-in-effect.

2.--SURPLUS-LINES-INSURANCE-BROKER'S-BOND-must-be-in-the-amount-of not--less--than--five--thousand--dollars--with--an--authorized corporate-surety-approved-by-the-commissioner-and-must-be-kept in-force-for-as-long-as-the-license-remains-in-effect.

3.--COMBINATION---INSURANCE---BROKER'S---BOND--and--SURPLUS--LINES INSURANCE-BROKER'S-BOND-must-be-in-the-amount-of-not-less-than ten--thousand-dollars-and-must-be-kept-in-force-for-as-long-as the-license-remains-in-effect.

4.--Each---surplus--lines--broker--shall--file--a--certificate--of insurance-with-the-commissioner,-and-shall-keep-in--force--for as--long--as--the--license--remains--in--effect,-an-errors-and omissions-insurance-policy-in-an-amount--not--less--than--five hundred-thousand-dollars.

ACKNOWLEDGMENT-FOR-INDIVIDUAL-AND-COPARTNERSHIP

STATE-OF----------)
ss.
COUNTY-OF---------)

On-this----------day-of----------,-19---,-before-me, a-Notary-Public-in-and-for-said-State-and--County,--personally--appeared ----------known--to--me--to-be-the-person----------who ----------described-in-and-who-executed-the--within--instrument, and--acknowledged-to-me-that----------he----------executed the-same.

Notary-Public

ACKNOWLEDGMENT-FOR-CORPORATION

STATE OF _____ }
ss.
COUNTY OF _____ }

On this _____ day of _____, 19___, personally appeared before me _____, to me personally known, who being by me duly sworn, did depose and say, he or she is _____ of _____ the corporation described in and which executed the foregoing instrument, that the seal affixed to the instrument is the corporate seal of the corporation, that the instrument was signed and sealed in behalf of the corporation by authority of its board of directors, and the corporation acknowledged the instrument to be free act and deed of the corporation.

_____
Notary Public

ACKNOWLEDGMENT-OF-SURETY

STATE OF _____ }
ss.
COUNTY OF _____ }

On this _____ day of _____, 19___, before me appeared _____, to me personally known, who being by me duly sworn did say that he or she is Attorney in fact for the _____ the corporation described in and which executed the foregoing instrument, that the seal affixed to the instrument is the corporate seal of the corporation, that the instrument was signed and sealed in behalf of the corporation by authority of its board of directors, and he or she acknowledged the instrument to be free act and deed of the corporation.

_____
Notary Public

APPENDIX-IIb

CONTINUATION-CERTIFICATE
Surety-Bond

_____
Name-of-Insurance-Company

_____
Address

In-Consideration-of-the-continuation-premium,-the-_____;
Surety-upon-Bond-No.-_____;-dated-the-_____-day-of
_____;-19___;-covering-_____and-in
favor-of-the-State-of-North-Dakota;-the-_____
(Kind-of-bond)
does-hereby-continue-the-bond-in-force-for-the-further-period-beginning
with-the-_____-day-of-_____;-19___;-and-ending-with
the-_____-day-of-_____;-19___.

The-liability-of-the-_____
under-the-bond-and-this-and-all-continuations-thereof
shall-not-be-cumulative.

Signed,-sealed,-and-dated-this-_____-day-of-_____;-19___.

Countersigned-by:-_____
(Name-of-Insurance-Company)

_____ _____
North-Dakota-Resident-Agent-----Attorney-in-fact

APPENDIX ~~III~~ II

Categories of Acceptable Surplus Lines Coverage

The following categories of surplus lines coverage are not the only lines which may be written in North Dakota. Other lines of coverage not on this list may be acceptable because of special underwriting considerations. Any exceptions must be fully explained on the surplus lines affidavit and approved by the insurance commissioner.

There is a presumption that the insured is unable, after diligent search, to procure the insurance, indemnity contract, or surety bond desired from a company authorized to do business in this state if the coverage written is in an approved category.

These categories may be changed from time to time at the discretion of the insurance commissioner subject to provisions of North Dakota Century Code chapter 28-32, the Administrative Agencies Practice Act.

1. Fiduciary liability.
2. Professional liability (E & O) except for hospitals.
3. Directors and officers.
4. Ocean marine cargo, liability and hull.
5. Hazardous cargo and short-term trip transit.
6. Bridges (large).
7. Heavy woodworking property (unprotected, high-value sawmills).
8. Product liability (hazardous).
9. Ski lifts and tows' liability.
10. Fireworks, ammunition, fuse, cartridges, power, nitroglycerine, explosive gases.
11. Environmental impairment - pollution.
12. Kidnap ransom.
13. Oil and gas liability and marine.
14. Livestock mortality (high values and unusual).
15. Short tail (hole-in-one, 300 bowling score, etc.).
16. Large utilities (generation, transmission).

17. Building demolition and moving.

18. Mono line liquor legal liability.

19. Surcharged fire and allied lines excluding uncontrolled marine.

20. High-value substandard private passenger ~~auto~~ automobile.

21. Commercial ~~auto~~ automobile physical damage coverage in excess of rating organizations' filed rates.

22. Any excess liability coverages.

23. Day care liability insurance coverages.

History: Amended effective February 1, 1983; November 1, 1987; December 1, 2001.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-02

APPENDIX ~~IV~~ III

Surplus ~~Line~~ Lines Affidavit

STATE OF NORTH DAKOTA)
) ss.
COUNTY OF _____)

_____ being first sworn on oath deposes and says:
Name of ~~Broker~~ Surplus Lines Insurance Producer

THAT ~~he~~ the affiant is a ~~resident~~ an insurance ~~agent~~ producer currently licensed under the North Dakota statutes, for the kind of insurance required;

THAT the insured is unable, after diligent search, to procure the insurance from a company authorized to do business in this state; and

THAT in order to procure the required insurance for the insured; it has been necessary to place part/all of same in a company/companies not licensed in this state.

1. Name of insured.

2. Address of insured.

3. D.B.A. - Name and address if different from above.

4. Location and description of risk.

5. Amount of coverage or limit of liability.

6. Date of application.

7. Term of policy.

~~7.~~ 8. Premium.

~~8.~~ 9. Surplus lines category #_____. (If no category applicable, describe the risk in greater detail providing justification for the use of an unauthorized carrier. The description and justification should be set out on a separate sheet of paper attached to and incorporated into the affidavit if there is insufficient room below.)

10. Name of producer if the business is placed with you by another insurance producer.

~~9.~~ 11. Unauthorized carrier used (complete name and address).

_____

Signature of ~~Broker~~ Surplus Lines Insurance Producer

Subscribed and sworn to before me this _____ day of _____, ~~19~~ 20 __. (Seal)

_____

Notary Public

APPENDIX-V

SURPLUS-LINES

STATE-OF-NORTH-DAKOTA
D-E-P-A-R-T-M-E-N-T--O-F--I-N-S-U-R-A-N-C-E
BISMARCK

STATEMENT-OF-TAXABLE-PREMIUMS-RECEIVED

ON-NORTH-DAKOTA-BUSINESS

Gross-direct-premiums--received--during-20___;
less-return-premiums,-refunds,-and-abatements
_____$_____

Less-dividends-paid-to-policyholders-or-used-in
reduction-of-premiums_____$_____

Total-taxable-premiums-balance_____$_____

Tax--liability-(one-and-three-fourths-percent--of
taxable-premiums)_____$_____

STATE-OF_____
ss:
COUNTY-OF_____

Surplus-lines-license-number_____

being--duly--sworn,--depose---and--say,-that--he-or--she-is--the--above surplus-lines-broker-and-that-the--foregoing--is--a--true--and--correct statement:

_____
Surplus-Lines-Broker

Subscribed-and-sworn-to-before-me
this-day-of_____,-20___:
_____
Notary-Public

APPENDIX IV

STATEMENT OF TAXABLE PREMIUMS RECEIVED ON NORTH DAKOTA BUSINESS
NORTH DAKOTA INSURANCE DEPARTMENT
SFN 17419 (8-01)

Gross Direct Premiums received during calendar year _____, less return premiums, refunds, and abatements	$
Less Dividends paid to policyholders or used in reduction of premiums	$
Total: Taxable Premiums Balance	$
Tax Liability (1 3/4% of Taxable Premiums)	$

Surplus Lines Insurance Producer	Surplus Lines License Number

I hereby certify that I am the above Surplus Lines Insurance Producer and that the foregoing is a true and correct statement.

_____
Signature

45-10-02-06. Reimbursement.

1. The fund will reimburse only reasonable and necessary 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. The application must contain at least the following information:

   a. Name and address of the owner ~~or~~, operator, or landowner.

   b. Street or highway description of the petroleum release location.

   c. The legal description of the release location.

   d. The substance released.

   e. The date the release was discovered.

   f. Name, address, and telephone number of the contact person.

   g. A narrative description of the release.

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 by order of federal, state, or local government.

   g. Any other expenses the administrator and the ~~advisory~~ 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 North Dakota state department of health or other federal or state agency approving the cleanup procedures.

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.

   j. Any cleanup costs resulting from negligence or misconduct on the part of the owner or operator.

   k. Costs in excess of those considered reasonable by the 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 ~~or~~, 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 fund 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 ~~or~~, operator, or ~~the owner's~~ landowner or ~~operator's~~ 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. All claims for payment are subject to the availability of funds in the petroleum tank release compensation fund and must be submitted no later than one year after the work has been completed to be eligible.

8. Prior to payment for any loss, the owner ~~or~~, operator, or landowner shall subrogate to the fund all rights, claims, and interest which the owner ~~or~~, 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 ~~or~~, 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 ~~or~~, operator, or landowner has submitted complete excavation or consultant worksheets along with legible copies of invoices, providing a description of:

   a. The work performed.

   b. The party who performed the work.

   c. The location where the work was performed.

   d. The date the work was performed.

   e. The unit cost.

   f. The total.

10. The owner ~~or~~, 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 ~~or~~, operator, or landowner or, if the owner ~~or~~, 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, federal, and local laws or 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.
General Authority: NDCC 28-32-02; S.L. 1991, ch. 299, § 5
Law Implemented: S.L. 1991, ch. 299, §§ 18, 20, 23, 24

45-10-02-06.1. Reimbursement disputes. If the fund administrator denies or reduces payment to a tank owner ~~or~~, operator, or landowner, the tank owner, operator, or landowner may request a review by the ~~advisory~~ board by filing a written request and supporting documentation with both the administrator and the ~~advisory~~ board within thirty days of receiving a proof of loss. The ~~advisory~~ board shall issue a written ~~opinion~~ decision concerning the issues in dispute within thirty days of receiving the written notice and supporting documentation. ~~The--opinion shall-be-advisory-only.~~ If after review by the ~~advisory~~ board a dispute still exists ~~between~~, the ~~fund~~ claimant or the administrator ~~and--the tank--owner--or--operator;--the--tank--owner--or-operator~~ may ~~request-an administrative-hearing~~ appeal the board decision to the commissioner. 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.
General Authority: NDCC 28-32-02; S.L. 1991, ch. 299, § 5
Law Implemented: S.L. 1991, ch. 299

45-10-02-08. ~~Advisory--board~~ Board. The administrator shall advise the board of the fund's general operations and review claims either through written correspondence, telephone conference calls, or ~~board~~ 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 28-32-02; S.L. 1991, ch. 299, § 5
Law Implemented: S.L. 1991, ch. 299, § 3

STAFF COMMENT: Article 45-14 contains all new material and is not underscored so as to improve readability.

ARTICLE 45-14

CONSUMER PRIVACY

CHAPTER 45-14-01
PRIVACY OF CONSUMER FINANCIAL AND HEALTH INFORMATION

45-14-01-01. Authority. This rule is adopted under North Dakota Century Code section 26.1-02-27.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-02. Purpose and scope.

1. **Purpose.** This chapter governs the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the state insurance department. This chapter:

   a. Requires a licensee to provide notice to individuals about its privacy policies and practices;

   b. Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

   c. Provides methods for individuals to prevent a licensee from disclosing that information.

2. **Scope.** This chapter applies to:

   a. Nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family, or household purposes from licensees. This chapter does not apply to information about companies or about individuals who obtain products or services for business, commercial, or agricultural purposes; and

   b. All nonpublic personal health information.

3. **Compliance.** A licensee domiciled in this state that is in compliance with this regulation in a state that has not enacted laws or rules that meet the requirements of title V of the Gramm-Leach-Bliley Act [Pub. L. 102-106] may nonetheless be deemed to be in compliance with title V of the Gramm-Leach-Bliley Act in the other state.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-03. Rule of construction. The examples in this chapter and the sample clauses in appendix A are not exclusive. Compliance with an example or use of sample clause, to the extent applicable, constitutes compliance with this chapter.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-04. Definitions. As used in this chapter, unless the context requires otherwise:

1. "Affiliate" means a company that controls, is controlled by, or is under common control with another company.

2. a. "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

   b. Examples:

      (1) Reasonably understandable. A licensee makes its notice reasonably understandable if it:

         (a) Presents the information in the notice in clear, concise sentences, paragraphs, and sections;

         (b) Uses short explanatory sentences or bullet lists whenever possible;

         (c) Uses definite, concrete, everyday words and active voice whenever possible;

         (d) Avoids multiple negatives;

         (e) Avoids legal and highly technical business terminology whenever possible; and

         (f) Avoids explanations that are imprecise and readily subject to different interpretations.

      (2) Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

         (a) Uses a plain-language heading to call attention to the notice;

         (b) Uses a typeface and type size that are easy to read;

(c) Provides wide margins and ample line spacing;

(d) Uses boldface or italics for key words; and

(e) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(3) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site such as text, graphics, hyperlinks, or sound do not distract attention from the notice, and the licensee either:

(a) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(b) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature, and relevance of the notice.

3. "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol, or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

4. "Commissioner" means the insurance commissioner of the state.

5. "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization.

6. a. "Consumer" means an individual who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative.

b. Examples:

(1) An individual who provides nonpublic personal information to a licensee in connection with

obtaining or seeking to obtain financial, investment, or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(2) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(3) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(4) An individual is a licensee's consumer if:

(a) [1] The individual is a beneficiary of a life insurance policy underwritten by the licensee;

[2] The individual is a claimant under an insurance policy issued by the licensee;

[3] The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

[4] The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

(b) The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under sections 45-14-01-14, 45-14-01-15, and 45-14-01-16.

(5) Provided that the licensee provides the initial, annual, and revised notices under sections 45-14-01-05, 45-14-01-06, and 45-14-01-09 to the plan sponsor, group or blanket insurance policyholder, or group annuity contractholder, and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under sections 45-14-01-14, 45-14-01-15, and 45-14-01-16, an individual is not the consumer of the licensee solely because the individual is:

(a) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary; or

(b) Covered under a group or blanket insurance policy or group annuity contract issued by the licensee.

(6) (a) The individuals described in subparagraphs a and b of paragraph 5 are consumers of a licensee if the licensee does not meet all the conditions of paragraph 5.

(b) In no event shall the individuals, solely by virtue of the status described in subparagraphs a and b of paragraph 5, be deemed to be customers for purposes of this rule.

(7) An individual is not a licensee's consumer solely because the individual is a beneficiary of a trust for which the licensee is a trustee.

(8) An individual is not a licensee's consumer solely because the individual has designated the licensee as trustee for a trust.

7. "Consumer reporting agency" has the same meaning as in section 603(f) of the federal Fair Credit Reporting Act [15 U.S.C. 1681a(f)].

8. "Control" means:

a. Ownership, control, or power to vote twenty-five percent or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

b. Control in any manner over the election of a majority of the directors, trustees, or general partners, or individuals exercising similar functions, of the company; or

c. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

9. "Customer" means a consumer who has a customer relationship with a licensee.

10. a. "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the

consumer that are to be used primarily for personal, family, or household purposes.

b. Examples:

(1) A consumer has a continuing relationship with a licensee if:

(a) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(b) The consumer obtains financial, investment, or economic advisory services relating to an insurance product or service from the licensee for a fee.

(2) A consumer does not have a continuing relationship with a licensee if:

(a) The consumer applies for insurance but does not purchase the insurance;

(b) The licensee sells the consumer travel insurance in an isolated transaction;

(c) The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(d) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(e) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(f) The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

(g) The individual is an insured or an annuitant under an insurance policy or annuity,

respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(h) For the purposes of this chapter, the individual's last-known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

11. a. "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in section 4(k) of the Bank Holding Company Act of 1956 [12 U.S.C. 1843(k)].

b. Financial institution does not include:

(1) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the commodity futures trading commission under the Commodity Exchange Act [U.S.C. 1 et seq.];

(2) The federal agricultural mortgage corporation or any entity charged and operating under the Farm Credit Act of 1971 [12 U.S.C. 2001 et seq.]; or

(3) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales, including sales of servicing rights, or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

12. a. "Financial product or service" means a product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under section 4(k) of the Bank Holding Company Act of 1956 [12 U.S.C. 1843(k)].

b. Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

13. "Health care" means:

a. Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests, or counseling that:

(1) Relates to the physical, mental, or behavioral condition of an individual; or

(2) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

b. Prescribing, dispensing, or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

14. "Health care provider" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law, or a health care facility.

15. "Health information" means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

a. The past, present, or future physical, mental, or behavioral health or condition of an individual;

b. The provision of health care to an individual; or

c. Payment for the provision of health care to an individual.

16. a. "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

b. Insurance service includes a licensee's evaluation, brokerage, or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

17. a. "Licensee" means all licensed insurers, producers, and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the insurance law of this state and health maintenance organizations holding a certificate of authority pursuant to North Dakota Century Code chapter 26.1-18.1. As used herein, the term "licensee" does not include either of the following:

(1) North Dakota life and health insurance guaranty association created pursuant to North Dakota Century Code chapter 26.1-38; or

(2) North Dakota insurance guaranty association created pursuant to North Dakota Century Code chapter 26.1-42.1.

b. A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in this chapter if the licensee is an employee, agent, or other representative of another licensee ("the principal") and:

(1) The principal otherwise complies with, and provides the notices required by, the provisions of this chapter; and

(2) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates unless in a manner permitted by this chapter.

c. (1) Subject to paragraph 2, "licensee" also includes an unauthorized insurer that accepts business placed through a licensed excess lines broker in this state, but only in regard to the excess lines placements placed pursuant to North Dakota Century Code chapter 26.1-44.

(2) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in this rule provided:

(a) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under section 45-14-01-14, except as permitted by section 45-14-01-15 or 45-14-01-16; and

(b) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in sixteen-point type:

PRIVACY NOTICE

"Neither the U.S. brokers that handled this insurance nor the insurers that have underwritten this insurance will disclose

nonpublic personal information concerning the buyer to nonaffiliates of the brokers or insurers except as permitted by law."

18. a. "Nonaffiliated third party" means any person except:

(1) A licensee's affiliate; or

(2) A person employed jointly by a licensee and any company that is not the licensee's affiliate, but nonaffiliated third party includes the other company that jointly employs the person.

b. Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in section 4(k)(4)(H) or insurance company investment activities of the type described in section 4(k)(4)(I) of the federal Bank Holding Company Act [12 U.S.C. 1843(k)(4)(H) and (I)].

19. "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

20. a. "Nonpublic personal financial information" means:

(1) Personally identifiable financial information; and

(2) Any list, description, or other grouping of consumers, and publicly available information pertaining to them, that is derived using any personally identifiable financial information that is not publicly available.

b. Nonpublic personal financial information does not include:

(1) Health information;

(2) Publicly available information, except as included on a list described in paragraph 2 of subsection a; or

(3) Any list, description, or other grouping of consumers, and publicly available information pertaining to them, that is derived without using any personally identifiable financial information that is not publicly available.

c. Examples of lists:

(1) Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

(2) Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

21. "Nonpublic personal health information" means health information:

a. That identifies an individual who is the subject of the information; or

b. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

22. a. "Personally identifiable financial information" means any information:

(1) A consumer provides to a licensee to obtain an insurance product or service from the licensee;

(2) About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

(3) The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

b. Examples:

(1) Information included. Personally identifiable financial information includes:

(a) Information a consumer provides to a licensee on an application to obtain an insurance product or service;

(b) Account balance information and payment history;

(c) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(d) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(e) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(f) Any information the licensee collects through an internet cookie, an information-collecting device from a web server; and

(g) Information from a consumer report.

(2) Information not included. Personally identifiable financial information does not include:

(a) Health information;

(b) A list of names and addresses of customers of an entity that is not a financial institution; and

(c) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names, or addresses.

23. a. "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

(1) Federal, state, or local government records;

(2) Widely distributed media; or

(3) Disclosures to the general public which are required to be made by federal, state, or local law.

b. Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(1) That the information is of the type that is available to the general public; and

(2) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

c. Examples:

(1) Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

(2) Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper, or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(3) Reasonable basis.

(a) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(b) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-05. Initial privacy notice to consumers required.

1. **Initial notice requirement.** A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

a. Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in subsection 5; and

b. Consumer. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by sections 45-14-01-15 and 45-14-01-16.

2. **When initial notice to a consumer is not required.** A licensee is not required to provide an initial notice to a consumer under subdivision b of subsection 1 if:

   a. The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by sections 45-14-01-15 and 45-14-01-16, and the licensee does not have a customer relationship with the consumer; or

   b. A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

3. **When the licensee establishes a customer relationship.**

   a. General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

   b. Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

      (1) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

      (2) Agrees to obtain financial, economic, or investment advisory services relating to insurance products or services for a fee from the licensee.

4. **Existing customers.** When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, the licensee satisfies the initial notice requirements of subsection 1 as follows:

   a. The licensee may provide a revised policy notice, under section 45-14-01-09, that covers the customer's new insurance product or service; or

   b. If the initial, revised, or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under subsection 1.

5. **Exceptions to allow subsequent delivery of notice.**

a. A licensee may provide the initial notice required by subdivision a of subsection 1 within a reasonable time after the licensee establishes a customer relationship if:

(1) Establishing the customer relationship is not at the customer's election; or

(2) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

b. Examples of exceptions:

(1) Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(2) Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(3) No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

6. **Delivery.** When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to section 45-14-01-10. If the licensee uses a short-form initial notice for noncustomers according to subsection 4 of section 45-14-01-07, the licensee may deliver its privacy notice according to subdivison c of subsection 4 of section 45-14-01-07.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-06. Annual privacy notice to customers required.

1. a. **General rule.** A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve consecutive months during which that relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

   b. Example. A licensee provides a notice annually if it defines the twelve-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year one, the licensee shall provide an annual notice to that customer by December 31 of year two.

2. a. **Termination of customer relationship.** A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

   b. Examples:

      (1) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

      (2) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

      (3) For the purposes of this rule, a licensee no longer has a continuing relationship with an individual if the individual's last-known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(4) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

3. **Delivery.** When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to section 45-14-01-10.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-07. Information to be included in privacy notices.

1. **General rule.** The initial, annual, and revised privacy notices that a licensee provides under sections 45-14-01-05, 45-14-01-06, and 45-14-01-09 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

   a. The categories of nonpublic personal financial information that the licensee collects;

   b. The categories of nonpublic personal financial information that the licensee discloses;

   c. The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under sections 45-14-01-15 and 45-14-01-16;

   d. The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under sections 45-14-01-15 and 45-14-01-16;

   e. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under section 45-14-01-14, and no other exception in sections

45-14-01-15 and 45-14-01-16 applies to that disclosure, a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

f. An explanation of the consumer's right under subsection 1 of section 45-14-01-11 to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

g. Any disclosures that the licensee makes under section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act [15 U.S.C. 1681a(d)(2)(A)(iii)] (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

h. The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

i. Any disclosure that the licensee makes under subsection 2.

2. **Description of parties subject to exceptions.** If a licensee discloses nonpublic personal financial information as authorized under sections 45-14-01-15 and 45-14-01-16, the licensee is not required to list those exceptions in the initial or annual privacy notices required by sections 45-14-01-05 and 45-14-01-06. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

3. **Examples:**

a. Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(1) Information from the consumer;

(2) Information about the consumer's transactions with the licensee or its affiliates;

(3) Information about the consumer's transactions with nonaffiliated third parties; and

(4) Information from a consumer reporting agency.

b. Categories of nonpublic personal financial information a licensee discloses.

(1) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in subdivision a, as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

(a) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address, and social security number;

(b) Transaction information, such as information about balances, payment history, and parties to the transaction; and

(c) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(2) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(3) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

c. Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(1) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(2) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking, or securities brokerage.

(3) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

d. Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in section 45-14-01-14 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of subdivision e of subsection 1 if it:

(1) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of subdivision b of subsection 1, as applicable; and

(2) States whether the third party is:

(a) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(b) A financial institution with whom the licensee has a joint marketing agreement.

e. Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under sections 45-14-01-15 and 45-14-01-16, the licensee may simply state that fact, in addition to the information it shall provide under subdivisions a, h, and i of subsection 1 and subsection 2.

f. Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(1) Describes in general terms who is authorized to have access to the information; and

(2) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

4. **Short-form initial notice with opt out notice for noncustomers.**

   a. A licensee may satisfy the initial notice requirements in subdivision b of subsection 1 of section 45-14-01-05 and subsection 3 of section 45-14-01-08 for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in section 45-14-01-08.

   b. A short-form initial notice shall:

      (1) Be clear and conspicuous;

      (2) State that the licensee's privacy notice is available upon request; and

      (3) Explain a reasonable means by which the consumer may obtain that notice.

   c. The licensee shall deliver its short-form initial notice according to section 45-14-01-10. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to section 45-14-01-10.

   d. Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

      (1) Provides a toll-free telephone number that the consumer may call to request the notice; or

      (2) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

5. **Future disclosures.** The licensee's notice may include:

   a. Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

   b. Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

6. **Sample clauses.** Sample clauses illustrating some of the notice content required by this section are included in appendix A.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-08. Form of opt out notice to consumers and opt out methods.

1. a. Form of opt out notice. If a licensee is required to provide an opt out notice under subsection 1 of section 45-14-01-11, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state:

(1) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

(2) That the consumer has the right to opt out of that disclosure; and

(3) A reasonable means by which the consumer may exercise the opt out right.

b. Examples:

(1) Adequate opt out notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

(a) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in subdivisions b and c of subsection 1 of section 45-14-01-07, and states that the consumer can opt out of the disclosure of that information; and

(b) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(2) Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

(a) Designates checkoff boxes in a prominent position on the relevant forms with the opt out notice;

(b) Includes a reply form together with the opt out notice;

(c) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

(d) Provides a toll-free telephone number that consumers may call to opt out.

(3) Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

(a) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(b) The only means of opting out as described in any notice subsequent to the initial notice is to use a checkoff box that the licensee provided with the initial notice but did not include with the subsequent notice.

(4) Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

2. Same form as initial notice permitted. A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with section 45-14-01-05.

3. Initial notice required when opt out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with section 45-14-01-05, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

4. Joint relationships:

a. If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out

notice shall explain how the licensee will treat an opt out direction by a joint consumer, as explained in subdivision e.

b. Any of the joint consumers may exercise the right to opt out. The licensee may either:

(1) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(2) Permit each joint consumer to opt out separately.

c. If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

d. A licensee may not require all joint consumers to opt out before it implements any opt out direction.

e. Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

(1) Send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary.

(2) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(3) Permit John and Mary to make different opt out directions. If the licensee does so:

(a) It shall permit John and Mary to opt out for each other;

(b) If both opt out, the licensee shall permit both of them to notify it in a single response, such as on a form or through a telephone call; and

(c) If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

5. Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

6. Continuing right to opt out. A consumer may exercise the right to opt out at any time.

7. Duration of consumer's opt out direction:

   a. A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

   b. When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

8. Delivery. When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to section 45-14-01-10.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-09. Revised privacy notices.

1. **General rule.** Except as otherwise authorized in this rule, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under section 45-14-01-05, unless:

   a. The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

   b. The licensee has provided to the consumer a new opt out notice;

   c. The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

   d. The consumer does not opt out.

2. **Examples.**

   a. Except as otherwise permitted by sections 45-14-01-14, 45-14-01-15, and 45-14-01-16, a licensee shall provide a revised notice before it:

      (1) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

      (2) Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

      (3) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

   b. A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

3. **Delivery.** When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to section 45-14-01-10.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-10. Delivery.

1. How to provide notices. A licensee shall provide any notices that this rule requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

2. a. Examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

      (1) Hand delivers a printed copy of the notice to the consumer;

      (2) Mails a printed copy of the notice to the last-known address of the consumer separately, or in a policy, billing, or other written communication;

      (3) For a consumer who conducts transactions electronically, posts the notice on the electronic

site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service; or

(4) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

b. Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(1) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(2) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

3. Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

a. The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

b. The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

4. Oral description of notice insufficient. A licensee may not provide any notice required by this rule solely by orally explaining the notice, either in person or over the telephone.

5. Retention or accessibility of notices for customers.

a. For customers only, a licensee shall provide the initial notice required by subdivision a of subsection 1 of section 45-14-01-05, the annual notice required by subsection 1 of section 45-14-01-06, and the revised notice required by section 45-14-01-09 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

b. Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

(1) Hand delivers a printed copy of the notice to the customer;

(2) Mails a printed copy of the notice to the last-known address of the customer; or

(3) Makes its current privacy notice available on a web site or a link to another web site for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

6. Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee may also provide a notice on behalf of another financial institution.

7. Joint relationships. If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual, and revised notice requirements of subsection 1 of section 45-14-01-05, subsection 1 of section 45-14-01-06, and subsection 1 of section 45-14-01-09, respectively, by providing one notice to those consumers jointly.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-11. Limits on disclosure of nonpublic personal financial information to nonaffiliated third parties.

1. a. Conditions for disclosure. Except as otherwise authorized in this rule, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(1) The licensee has provided to the consumer an initial notice as required under section 45-14-01-05;

(2) The licensee has provided to the consumer an opt out notice as required in section 45-14-01-08;

(3) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) The consumer does not opt out.

b. Opt out definition. Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by sections 45-14-01-14, 45-14-01-15, and 45-14-01-16.

c. Examples of reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if:

(1) By mail. The licensee mails the notices required in subdivision a to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number, or any other reasonable means within thirty days from the date the licensee mailed the notices.

(2) By electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices required in subdivision a electronically, and the licensee allows the customer to opt out by any reasonable means within thirty days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(3) Isolated transaction with consumer. For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in subdivision a at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

2. Application of opt out to all consumers and all nonpublic personal financial information.

a. A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

b. Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the

licensee collected it before or after receiving the direction to opt out from the consumer.

3. Partial opt out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-12. Limits on redisclosure and reuse of nonpublic personal financial information.

1. a. Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in section 45-14-01-05 or 45-14-01-16, the licensee's disclosure and use of that information is limited as follows:

   (1) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

   (2) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

   (3) The licensee may disclose and use the information pursuant to an exception in section 45-14-01-15 or 45-14-01-16, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

   b. Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

2. a. Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in section 45-14-01-15 or 45-14-01-16, the licensee may disclose the information only:

(1) To the affiliates of the financial institution from which the licensee received the information;

(2) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(3) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

b. Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in section 45-14-01-15 or 45-14-01-16:

(1) The licensee may use that list for its own purposes; and

(2) The licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in section 45-14-01-15 or 45-14-01-16, such as to the licensee's attorneys or accountants.

3. Information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in section 45-14-01-15 or 45-14-01-16, the third party may disclose and use that information only as follows:

a. The third party may disclose the information to the licensee's affiliates;

b. The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

c. The third party may disclose and use the information pursuant to an exception in section 45-14-01-15 or 45-14-01-16 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

4. Information a licensee discloses outside of an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in section 45-14-01-15 or 45-14-01-16, the third party may disclose the information only:

   a. To the licensee's affiliates;

   b. To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

   c. To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-13. Limits on sharing account number information for marketing purposes.

1. **General prohibition on disclosure of account numbers.** A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

2. **Exceptions.** Subsection 1 does not apply if a licensee discloses a policy number or similar form of access number or access code:

   a. To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

   b. To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

   c. To a participant in an affinity or similar program when the participants in the program are identified to the customer when the customer enters into the program.

3. **Examples.**

   a. Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not

provide the recipient with a means to decode the number or code.

b. Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-14. Exception to opt out requirements for disclosure of nonpublic personal financial information for service providers and joint marketing.

1. **General rule.**

   a. The opt out requirements in sections 45-14-01-08 and 45-14-01-11 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

      (1) Provides the initial notice in accordance with section 45-14-01-05; and

      (2) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in section 45-14-01-15 or 45-14-01-16 in the ordinary course of business to carry out those purposes.

   b. Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of paragraph 2 of subdivision a if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in section 45-14-01-15 or 45-14-01-16 in the ordinary course of business to carry out that joint marketing.

2. **Service may include joint marketing.** The services a nonaffiliated third party performs for a licensee under subsection 1 may include marketing of the licensee's own

products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

3. **Definition of joint agreement.** For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse, or sponsor a financial product or service.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-15. Exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information for processing and servicing transactions.

1. Exceptions for processing transactions at consumer's request. The requirements for initial notice in subdivision b of subsection 1 of section 45-14-01-05, the opt out in sections 45-14-01-08 and 45-14-01-11, and service providers and joint marketing in section 45-14-01-14 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes, or in connection with:

   a. Servicing or processing an insurance product or service that a consumer requests or authorizes;

   b. Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

   c. A proposed or actual securitization, secondary market sale, including sales of servicing rights, or similar transaction related to a transaction of the consumer;

   d. Reinsurance or stop-loss or excess loss insurance; or

   e. Informing a policyholder or the policyholder's producer or broker with respect to a claim asserted by, or paid to, a consumer under the policy and servicing and processing such claim.

2. "Necessary to effect, administer, or enforce a transaction" means that the disclosure is:

   a. Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

b. Required, or is a usual, appropriate, or acceptable method:

(1) To carry out the transaction or the product or service business of which the transaction is a part, and record, service, or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(2) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(3) To provide a confirmation, explanation, statement, or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's producer or a policyholder or the policyholder's agent, producer, or broker with respect to a claim asserted by, or paid to, a consumer under a policy;

(4) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(5) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance or the policyholder's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing, adjusting, paying, and settling insurance claims, administering insurance benefits including utilization review activities, participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(6) In connection with:

(a) The authorization, settlement, billing, processing, clearing, transferring, reconciling, or collection of amounts charged, debited, or otherwise paid using a debit, credit, or other payment card, check or account number, or by other payment means;

(b) The transfer of receivables, accounts, or interests therein; or

(c) The audit of debit, credit, or other payment information.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-16. Other exceptions to notice and opt out requirements for disclosure of nonpublic personal financial information.

1. **Exceptions to opt out requirements.** The requirements for initial notice to consumers in subdivision b of subsection 1 of section 45-14-01-05, the opt out in sections 45-14-01-08 and 45-14-01-11, and service providers and joint marketing in section 45-14-01-14 do not apply when a licensee discloses nonpublic personal financial information:

   a. With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

   b. (1) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction;

      (2) To protect against or prevent actual or potential fraud or unauthorized transactions;

      (3) For required institutional risk control or for resolving consumer disputes or inquiries;

      (4) To persons holding a legal or beneficial interest relating to the consumer; or

      (5) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

   c. To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants, and auditors;

   d. To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 [12 U.S.C. 3401 et seq.], to law enforcement agencies including the federal reserve board, office of the comptroller of the currency, federal deposit insurance corporation, office of thrift supervision, national credit union administration, the securities and exchange commission, the secretary of the treasury, with respect to 31 U.S.C. chapter 53,

subchapter II (records and reports on monetary instruments and transactions) and 12 U.S.C. chapter 21 (financial recordkeeping), a state insurance authority, and the federal trade commission, self-regulatory organizations, or for an investigation on a matter related to public safety;

e. (1) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act [15 U.S.C. 1681 et seq.]; or

(2) From a consumer report reported by a consumer reporting agency;

f. In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

g. (1) To comply with federal, state, or local laws, rules, and other applicable legal requirements;

(2) To comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, state, or local authorities; or

(3) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law; or

h. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or a workers' compensation plan.

2. **Example of revocation of consent.** A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under subsection 6 of section 45-14-01-08.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-17. When authorization required for disclosure of nonpublic personal health information.

1. A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose

nonpublic personal health information is sought to be disclosed.

2. Nothing in this section shall prohibit, restrict, or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of the following insurance functions by or on behalf of the licensee or its affiliate: claims administration; claims adjustment and management; detection, investigation, or reporting of actual or potential fraud, misrepresentation, or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical, or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; data base security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers' compensation policy or program; activities in connection with a sale, merger, transfer, or exchange of all or part of a business or operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the United States department of health and human services; disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process. Additional insurance functions may be added with the approval of the commissioner to the extent they are necessary for appropriate performance of insurance functions and are fair and reasonable to the interest of consumers.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-18. Authorizations.

1. A valid authorization to disclose nonpublic personal health information pursuant to sections 45-14-01-17 through 45-14-01-21 shall be in written or electronic form and shall contain all of the following:

a. The identity of the consumer or customer who is the subject of the nonpublic personal health information;

b. A general description of the types of nonpublic personal health information to be disclosed;

c. General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure, and how the information will be used;

d. The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed; and

e. Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

2. An authorization pursuant to sections 45-14-01-17 through 45-14-01-21 shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four months.

3. A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to sections 45-14-01-17 through 45-14-01-21 at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

4. A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-19. Authorization request delivery. A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt out notice pursuant to section 45-14-01-10, provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices

unless the licensee intends to disclose protected health information pursuant to subsection 1 of section 45-14-01-17.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-20. Relationship to federal rules. Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rule as promulgated by the United States department of health and human services [45 CFR subtitle A, subchapter C, part 160] (the "federal rule"), if a licensee complies with all requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provisions of sections 45-14-01-17 through 45-14-01-21.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-21. Relationship to state laws. Nothing in this rule shall preempt or supersede existing state law related to medical records, health, or insurance information privacy.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-22. Protection of Fair Credit Reporting Act. Nothing in this rule shall be construed to modify, limit, or supersede the operation of the federal Fair Credit Reporting Act [15 U.S.C. 1681 et seq.], and no inference shall be drawn on the basis of the provisions of this rule regarding whether information is transaction or experience information under section 603 of that Act.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-23. Nondiscrimination.

1. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of the person's nonpublic personal financial information pursuant to the provisions of this regulation.

2. A licensee shall not unfairly discriminate against a consumer or customer because that consumer or customer has not granted

authorization for the disclosure of the person's nonpublic personal health information pursuant to the provisions of this rule.

3. Usual, appropriate, or acceptable insurance underwriting methods are not discriminatory practices for the purposes of this section.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-24. Severability. If any section or portion of a section of this chapter or its applicability to any person or circumstance is held invalid by a court, the remainder of the rule or the applicability of the provision to other persons or circumstances shall not be affected.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

45-14-01-25. Compliance date.

1. Compliance date. A company must comply with this chapter by its effective date.

2. a. Notice requirement for consumers who are the licensee's customers on the compliance date. By this chapter's effective date, a licensee shall provide an initial notice, as required by section 45-14-01-05, to consumers who are the licensee's customers on this rule's effective date.

   b. Example. A licensee provides an initial notice to consumers who are its customers on this chapter's effective date if, by that date, the licensee has established a system for providing an initial notice to all new customers and has mailed the initial notice to all the licensee's existing customers.

3. Grandfathering of service agreements. Until March 1, 2003, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of paragraph 2 of subdivision a of subsection 1 of section 45-14-01-14, even if the contract does not include a requirement that the third party maintain the confidentiality

of nonpublic personal information, as long as the licensee entered into the agreement on or before March 1, 2001.

History: Effective December 1, 2001.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-27

APPENDIX A
SAMPLE CLAUSES

The examples in this rule and the sample clauses in this appendix are not exclusive. Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this rule.

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. Note that disclosure of certain information, such as assets, income, and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.

A-1-Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of subdivision a of subsection 1 of section 45-14-01-07 to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and
- Information we receive from a consumer reporting agency.

A-2-Categories of information a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of subdivision b of subsection 1 of section 45-14-01-07 to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in sections 45-14-01-14, 45-14-01-15, and 45-14-01-16.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as **[provide illustrative examples, such as "your**

name, address, social security number, assets, income, and beneficiaries"];

- Information about your transactions with us, our affiliates, or others, such as **[provide illustrative examples, such as "your policy coverage, premiums, and payment history"]**; and

- Information we receive from a consumer reporting agency, such as **[provide illustrative examples, such as "your creditworthiness and credit history"]**.

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect, as described **[describe location in the notice, such as "above" or "below"]**.

A-3-Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of subdivisions b, c, and d of subsection 1 of section 45-14-01-07 to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in sections 45-14-01-15 and 45-14-01-16.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4-Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of subdivision c of subsection 1 of section 45-14-01-07 to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in sections 45-14-01-14, 45-14-01-15, and 45-14-01-16, as well as when permitted by the exceptions in sections 45-14-01-15 and 45-14-01-16.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as **[provide illustrative examples, such as "life insurers, automobile insurers,**

mortgage bankers, securities broker-dealers, and insurance agents"];

- Nonfinancial companies, such as **[provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]**; and

- Others, such as **[provide illustrative examples, such as "nonprofit organizations"].**

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5-Service provider/joint marketing exception

A licensee may use one of these clauses, as applicable, to meet the requirements of subdivision e of subsection 1 of section 45-14-01-07 related to the exception for service providers and joint marketers in section 45-14-01-14. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as **[provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];**

- Information about your transactions with us, our affiliates, or others, such as **[provide illustrative examples, such as "your policy coverage, premium, and payment history"]**; and

- Information we receive from a consumer reporting agency, such as **[provide illustrative examples, such as "your creditworthiness and credit history"].**

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6-Explanation of opt out right (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of subdivision f of subsection 1 of section 45-14-01-07 to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the methods by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in sections 45-14-01-14, 45-14-01-15, and 45-14-01-16.

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures other than disclosures permitted by law. If you wish to opt out of disclosures to nonaffiliated third parties, you may **[describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)]**.

A-7-Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of subdivision h of subsection a of section 45-14-01-07 to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to **[provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]**. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

TITLE 61

Pharmacy, Board of

OCTOBER 2001

STAFF COMMENT: Chapter 61-02-08 contains all new material and is not underscored so as to improve readability.

CHAPTER 61-02-08
TELEPHARMACY PILOT PROJECT RULES

61-02-08-01. Purpose and scope.

1. The state board of pharmacy is responsible for maintaining, continuing, and enhancing the development of the education and professional role of the pharmacist for the protection of the health, welfare, and safety of the citizens of North Dakota.

2. Rural North Dakota is facing an accessibility problem due to closing pharmacies.

3. In order to maintain or make pharmacy services available in areas that have lost their pharmacies or are in jeopardy of losing their pharmacies, rules are necessary to establish a pilot project for telepharmacies.

4. This chapter applies to a pilot project of up to five central pharmacies, each with one or more remote sites. Both the

central pharmacy and remote site must be located within the state.

History: Effective October 1, 2001.
General Authority: NDCC 43-15-10(7)(9)(11)(12)(14)(19)
Law Implemented: NDCC 43-15-10, 43-15-32, 43-15-34, 43-15-35

61-02-08-02. Definitions.

1. "Remote site" means a pharmacy staffed by a registered pharmacy technician with access to its main pharmacy and registered pharmacists by computer link, videolink, and audiolink while open.

2. "Telepharmacy" means a central pharmacy with one or more remote sites in which all sites are connected via computer link, videolink, and audiolink.

History: Effective October 1, 2001.
General Authority: NDCC 43-15-10(7)(9)(11)(12)(14)(19)
Law Implemented: NDCC 43-15-10, 43-15-32, 43-15-34, 43-15-35

61-02-08-03. Operations.

1. A remote site shall comply with North Dakota Century Code section 43-15-35 governing requirements for a permit to operate a pharmacy. The remote site is considered to be under the personal charge of the pharmacist at the central pharmacy.

2. A remote site shall be connected to its central pharmacy via computer link, videolink, and audiolink.

3. A remote site shall use its central pharmacy's central processing unit.

   a. Consecutive prescription numbers and all prescription records must be maintained at the central pharmacy.

   b. Prescriptions filled at the remote site must be distinguishable on records from those filled at the central pharmacy.

   c. Daily reports must be separated for the central pharmacy and the remote site but must be maintained at the central pharmacy.

   d. Pharmacies must be able to generate labels from the central pharmacy or at the remote site.

   e. All prescriptions distributed at the remote site must have a label that meets requirements set forth in chapter

61-04-06 attached to the final drug container before the pharmacist verifies the dispensing process.

4. A pharmacist at the central pharmacy must approve each prescription before it leaves the remote site.

   a. Dispensing is considered to be done at the central pharmacy.

   b. Both the pharmacist's and the technician's initials must appear on the fill screen, patient profile, and label.

   c. A pharmacist shall compare via videolink the stock bottle, drug dispensed, and strength. The entire label must be checked for accuracy on the videolink.

5. Counseling must be done by a pharmacist via videolink and audiolink. The pharmacist must counsel the patient or the patient's agent on all new prescriptions and refills.

6. A pharmacist must complete monthly inspections of the remote site. Inspection criteria must be included in the policies and procedures for the site. The inspection reports must be maintained until the next state board of pharmacy inspection.

7. The remote site may have a prescription inventory. Controlled substances shall be kept at the remote site in accordance with North Dakota Century Code chapter 19-03.1, the Uniform Controlled Substances Act.

   a. If controlled substances are kept, the remote site must be registered with the drug enforcement administration and obtain its own drug enforcement administration number.

   b. All records must be stored at the central pharmacy.

8. There must be policies and procedures in place to ensure the safe and effective distribution of pharmaceutical products and delivery of required pharmaceutical care. There must be an ongoing review of incident reports and outcomes, with appropriate corrective action taken when necessary, to ensure there is no abnormal frequency of errors in dispensing drugs or devices.

9. The telepharmacy location must be in compliance with chapter 61-02-02, building standards for pharmacies; chapter 61-02-03, security standards for pharmacies; and chapter 61-02-04, sanitary standards for pharmacies; except as otherwise provided in this chapter.

10. The permitholder or the pharmacist in charge of the central pharmacy must apply for a permit for the remote site. A class K permit is established under section 61-02-01-01 for

the purpose of conducting a telepharmacy as part of a pilot project. These permits are issued to a remote site connected to a central pharmacy via computer link, videolink, and audiolink.

History: Effective October 1, 2001.
General Authority: NDCC 43-15-10(7)(9)(11)(12)(14)(19)
Law Implemented: NDCC 43-15-10, 43-15-32, 43-15-34, 43-15-35

61-02-08-04. Rule exceptions. To the extent of a conflict with any provision of this title, the provisions of this chapter govern with respect to a telepharmacy and remote site operating in compliance with this chapter. With the following conditions, this chapter is an exception to the following rules:

1. Pharmacist on duty under section 61-02-01-13. The remote site must have a registered pharmacy technician present and a working computer link, videolink, and audiolink to a pharmacist at the central pharmacy to have the prescription area open. The communication link must be checked daily and the remote site pharmacy must be closed if the link malfunctions, unless a pharmacist is at the remote site.

   a. The technician must be registered with the state board of pharmacy and have at least one year of work experience as a North Dakota-registered pharmacy technician.

   b. The technician must be a graduate of an approved pharmacy technician education program or must make application to the board, and must demonstrate knowledge and experience in preparation of prescriptions for dispensing and working with patients.

   c. The technician will be subject to all rules in chapter 61-02-07.1, excluding the ratio of pharmacists to pharmacy technicians. A pharmacist may oversee no more than four remote sites. As dispensing is considered done by the pharmacist, the pharmacist will be responsible for and held accountable for the remote site.

2. Security standards for pharmacies under subsections 3, 4, 6, 7, and 9 of section 61-02-03-01. The pharmacy technician may unlock the prescription and storage areas. While the technician is on duty, the prescription area may remain open.

3. Input of drug information into electronic data processing equipment under section 61-02-06-01. The input of drug information shall be done by a pharmacist at the central pharmacy or, if entered by the technician at the remote site, must be verified by a pharmacist.

a. New prescriptions may be received and entered at the central pharmacy with a label printed at the remote site.

b. New prescriptions received at the remote site may be entered into the remote computer system with all verification, interaction checking, and profile review the responsibility of the pharmacist at the central pharmacy.

History: Effective October 1, 2001.
General Authority: NDCC 43-15-10(7)(9)(11)(12)(14)(19)
Law Implemented: NDCC 43-15-10, 43-15-32, 43-15-34, 43-15-35

61-02-08-05. Suspension and termination.

1. The board may suspend immediately the permit of any class K pharmacy if a danger to the public exists.

2. The board may terminate all of the class K pilot project permits pursuant to North Dakota Century Code chapter 28-32. A sixty-day notice will be sent to the pharmacist in charge of each project.

History: Effective October 1, 2001.
General Authority: NDCC 43-15-10(7)(9)(11)(12)(14)(19)
Law Implemented: NDCC 43-15-28.1

61-02-08-06. Expiration. This chapter is effective through May 15, 2005, and is thereafter ineffective unless specifically extended by rule.

History: Effective October 1, 2001.
General Authority: NDCC 43-15-10(7)(9)(11)(12)(14)(19)
Law Implemented: NDCC 43-15-10, 43-15-32, 43-15-34, 43-15-35

TITLE 75

Department of Human Services

OCTOBER 2001

CHAPTER 75-02-02

AGENCY SYNOPSIS: The department proposed amendments to North Dakota Administrative Code Chapter 75-02-02, Medical Services, conducted a public hearing on those rules on March 14, 2001, and received written comment on those proposed rules until the end of the day on April 17, 2001.

75-02-02-03.2, Definitions: This section is amended to add definitions for "Certification of need," "County agency," "Rehabilitative services," "Residential treatment center for children"; and to renumber accordingly.

75-02-02-09(3), Nursing facility level of care: This subsection is amended to delete the language in subdivision g which states that "The individual has resided in the nursing facility, from and after January 1, 1993, and is not transferring to another facility."

75-02-02-09(4), Nursing facility level of care: This subsection is amended to clarify ambiguous language and removes former subdivision b which states: "The nursing facility, to which the individual is applying or in which the individual is residing, exclusively provides residential services for nongeriatric, physically handicapped individuals."

75-02-02-09(5), Nursing facility level of care: This subsection is amended to add language to ensure that if no criteria of subsection 2, 3, or 4 is met, an individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if the individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury;

and as a result of the brain injury, the individual requires direct supervision at least eight hours a day; and to renumber accordingly.

75-02-02-10(1)(b), Limitations on inpatient psychiatric services: This section is amended to replace "psychiatric facility, or an inpatient program in a psychiatric facility," with "psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the joint commission on accreditation of health care organizations, or by a psychiatric facility."

75-02-02-03.2. Definitions. For purposes of this chapter:

1. "Certification of need" means a regulatory review process that requires specific health care providers to obtain prior authorization for provision of services for medicaid applicants or eligible recipients. Certification of need applications are required for all residential treatment center applicants or recipients of a psychiatric hospital or an inpatient psychiatric program in a hospital and a psychiatric facility, including residential treatment centers to determine the medical necessity of the proposed services. The certification of need evaluates the recipient's capacity to benefit from proposed services, the efficacy of proposed services, and consideration of the availability of less restrictive services to meet the individual's needs.

2. "County agency" means the county social service board.

~~2.~~ 3. "Department" means the North Dakota department of human services.

~~3.~~ 4. "Home health agency" means a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act, or is determined currently to meet the requirements for participation.

~~4.~~ 5. "Medical emergency" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

~~5.~~ 6. "Medically necessary" includes only medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the patient's diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided

only as a convenience to the patient or provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective.

6. 7. "Provider" means an individual, entity, or facility furnishing medical or remedial services or supplies pursuant to a provider agreement with the department.

7. 8. "Recipient" means an individual approved as eligible for medical assistance.

9. "Rehabilitative services" means any medical remedial items or services prescribed for a patient by the patient's physician or other licensed practitioner of the healing arts, within the scope of the physician's or practitioner's practice as defined by state law, for the purpose of maximum reduction of physical or mental disability and restoration of the patient to the patient's best possible functional level.

8. 10. "Remedial services" includes those services, including rehabilitative services, which produce the maximum reduction in physical or mental disability and restoration of a recipient to the recipient's best possible functional level.

11. "Residential treatment center for children" means a facility or a distinct part of a facility that provides to children and adolescents a total, twenty-four hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own family, in another home, or in a less restrictive setting.

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

10. 13. "Section 1931 group" includes individuals whose eligibility is based on the provisions of section 1931 of the Social Security Act [42 U.S.C. 1396u-1].

History: Effective May 1, 2000; amended effective August 29, 2000; November 1, 2001.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02-09. Nursing facility level of care.

1. "Nursing facility level of care" means, for purposes of medical assistance, services provided by a facility that meets the standards for nursing facility licensing established by the state department of health, and in addition, meets all requirements for nursing facilities imposed under federal law and regulations governing the medical assistance program.

2. Except as provided in subsection 3 or 4, an individual who applies for care in a nursing facility, or who resides in a nursing facility, may demonstrate that a nursing facility level of care is medically necessary only if any one of the criteria in this subsection is met.

   a. The individual's nursing facility stay is, or is anticipated to be, temporary for receipt of medicare part A benefits. A nursing facility stay may be based on this criterion for no more than fourteen days after termination of medicare part A benefits.

   b. The individual is in a comatose state.

   c. The individual requires the use of a ventilator at least six hours per day.

   d. The individual has respiratory problems that require regular treatment, observation, or monitoring that may only be provided by or under the direction of a registered nurse ~~(or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse)~~, and is incapable of self-care.

   e. The individual requires constant help sixty percent or more of the time with at least two of the activities of daily living of toileting, eating, transferring, and locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

   f. The individual requires aspiration for maintenance of a clear airway.

   g. The individual has dementia, physician-diagnosed or supported with corroborative evidence, for at least six months, and as a direct result of that dementia, the individual's condition has deteriorated to the point where when a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.

3. If no criteria of subsection 2 is met, an individual who applies for care in a nursing facility or who resides in a nursing facility may demonstrate that a nursing facility level

of care is medically necessary if any two of the criteria in this subsection are met.

a. The individual requires administration of prescribed:

(1) Injectable medication;

(2) Intravenous medication or solutions ~~(~~on a daily basis~~)~~; or

(3) Routine oral medications, eye drops, or ~~(~~ointments on a daily basis~~)~~.

b. The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse ~~(~~or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse~~)~~.

c. The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments, such as gait training or bowel and bladder training, which are provided at least five days per week.

d. The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.

e. The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.

f. The individual requires constant help sixty percent or more of the time with any one of the activities of daily living of toileting, eating, transferring, or locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

~~g.--The--individual--has-resided-in-the-nursing-facility,-from and-after-January-1,-1993,--and--is--not--transferring--to another-facility.~~

4. If no criteria of subsection 2 or 3 is met, an individual who applies ~~for-care~~ to or resides in a nursing facility ~~or--who resides--in--a--nursing--facility~~ designated as a facility for nongeriatric individuals with physical disabilities may demonstrate that a nursing facility level of care is medically necessary if:

a.~~--The~~ the individual is determined to have restorative potential;~~-and~~

~~b.--The--nursing-facility,-to-which-the-individual-is-applying or--in--which--the--individual--is--residing,--exclusively provides-residential-services-for-nongeriatric,-physically handicapped-individuals.~~

5. If no criteria of subsection 2, 3, or 4 is met, an individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if:

   a. The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; and

   b. As a result of the brain injury, the individual requires direct supervision at least eight hours a day.

6. a. Payment, by the department of human services, for care furnished in a nursing facility to individuals who were applicants for or recipients of medical assistance benefits prior to admission to the nursing facility may be made only for periods after a nursing facility level of care determination is made. If a nursing facility admits an individual who has applied for or is receiving medical assistance benefits before a nursing facility level of care determination is made, the nursing facility may not solicit or receive payment, from any source, for services furnished before the level of care determination is made.

   b. Payment, by the department of human services, for care furnished in a nursing facility to individuals who become applicants for or recipients of medical assistance benefits after admission to the nursing facility may be made only after a nursing facility level of care determination is made.

   c. Payment, by the department of human services, for care furnished in a nursing facility to individuals who are eligible for medicare benefits related to that care, and who are also eligible for medical assistance, may be made only after a nursing facility level of care determination is made.

~~6.~~ 7. A nursing facility shall ensure that appropriate medical, social, and psychological services are provided to each resident of the facility who is dependent in whole or in part on the medical assistance program under title XIX of the Social Security Act. The appropriateness of such services must be based on the need of each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and must consider, among other factors, age.

History: Amended effective September 1, 1979; July 1, 1993; November 1, 2001.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 442

75-02-02-10. Limitations on inpatient psychiatric services.

1. Inpatient psychiatric services for individuals under age twenty-one must be provided:

   a. Under the direction of a physician;

   b. By a psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the joint commission on accreditation of health care organizations, or by a psychiatric facility; ~~or an inpatient program in a psychiatric facility;~~ which is accredited by the joint commission on accreditation of health care organizations; and

   c. Before the individual reaches age twenty-one, or, if the individual was receiving inpatient psychiatric services immediately before reaching age twenty-one, before the earlier of:

      (1) The date the individual no longer requires inpatient psychiatric services; or

      (2) The date the individual reaches age twenty-two.

2. A psychiatric facility or program providing inpatient psychiatric services to individuals under age twenty-one must:

   a. Except as provided in subdivision c, obtain a certification of need from an independent review team qualified under subsection 3 prior to admitting an individual who is eligible for medical assistance;

   b. Obtain a certification of need from a team responsible for developing a plan of care under 42 CFR 441.156 for an individual who applies for medical assistance while in the facility or program covering any period for which claims are made; or

   c. Obtain a certification of need from a team responsible for developing a plan of care under 42 CFR 441.156 for an emergency admission of an individual, within fourteen days after the admission, covering any period prior to the certification for which claims are made.

3. a. An independent review team must:

(1) Be composed of individuals who have no business or personal relationship with the inpatient psychiatric facility or program requesting a certification of need;

(2) Include a physician;

(3) Have competence in diagnosis and treatment of mental illness; and

(4) Have adequate knowledge of the situation of the individual for whom the certification of need is requested.

b. Before issuing a certification of need, an independent review team must use professional judgment and standards approved by the department and consistent with the requirements of 42 CFR part 441, subpart D, to demonstrate:

(1) Ambulatory care resources available in the community do not meet the treatment needs of the individual;

(2) Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) The requested services can reasonably be expected to improve the individual's condition or prevent further regression so services may no longer be needed.

4. No payment will be made for inpatient psychiatric services provided to recipients, other than those described in subsection 1, in a distinct part unit of a hospital except for the first twenty-one days of each admission.

History: Amended effective January 1, 1997; November 1, 2001.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 441, subpart D

75-02-02-10.1. Limitations on rehabilitative services in residential treatment centers.

1. A residential treatment center providing rehabilitative services to individuals under the age of twenty-one must obtain a certification of need from an independent review team:

a. Prior to admitting an individual who is eligible for medical assistance;

b. For an individual who applies for medical assistance while in the facility; or

c. For an individual who applies for medical assistance after receiving services.

2. Before issuing a certification of need, an independent review team must demonstrate that:

a. Ambulatory care resources available in the community do not meet the treatment needs of the individual;

b. Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c. The requested services can reasonably be expected to improve the individual's condition or prevent further regression so services may no longer be needed.

3. An independent review team must:

a. Be composed of individuals who have no business or personal relationship with the residential treatment center requesting a certification of need;

b. Include a physician;

c. Have competence in diagnosis and treatment of mental illness; and

d. Have adequate knowledge of the situation of the individual for whom the certification is requested.

4. Payment will not be made for rehabilitation services provided to a recipient under the age of twenty-one in a residential treatment center without a certification of need.

History: Effective November 1, 2001.
General Authority: NDCC 50-24.1-04; 42 CFR 456.1; 42 CFR 456.3
Law Implemented: NDCC 50-24.1-04; 42 CFR Part 441, subpart D

TITLE 97

Board of Counselor Examiners

DECEMBER 2001

CHAPTER 97-02-01.1

97-02-01.1-04. Fees. The following fees have been established by the board for the licensed professional clinical counselor license:

1. Application fee, one hundred fifty dollars.

2. Renewal fee, ~~twenty~~ fifty dollars.

History: Effective August 1, 1996; amended effective December 1, 2001.
General Authority: NDCC 28-32-02 28-32-02(1), 43-47-03(3)
Law Implemented: NDCC ~~43-47-06.1~~ 43-47-03(3)

97-02-01.1-06. Definitions. As used in this title, unless the context otherwise requires:

1. "Clinical counseling" means providing clinical mental health counseling services involving the application of principles of human development, learning theory, psychotherapy, group dynamics, and the etiology of mental illness and dysfunctional behavior to individuals, couples, families, and groups for the purpose of promoting optimal mental health, dealing with normal problems of living, and treating psychopathic disorders. Clinical counseling includes diagnosis and treatment of emotional and mental disorders; psycho-educational techniques aimed at the prevention of emotional and mental disorders; consultations to individuals, couples, families, groups, organizations, and communities; and clinical research into more effective psycho-therapeutic modalities.

2. "Licensed professional clinical counselor" means a person who is licensed under this chapter to practice the specialty of clinical counseling.

History: Effective December 1, 2001
General Authority: NDCC 28-32-02(1), 43-47-06.1
Law Implemented: NDCC 43-47-06.1

97-02-01.1-07. Representation to the public. Only persons licensed under this chapter may use the title "licensed professional clinical counselor" or the abbreviation "LPCC".

History: Effective December 1, 2001
General Authority: NDCC 28-32-02(1), 43-47-06.1
Law Implemented: NDCC 43-47-06.1

CHAPTER 97-02-03

97-02-03-01. Code of ethics. The board adopts the ~~ethical standards of the~~ American counseling association ~~(~~Code of Ethics and Standards of Practice and the Ethical Standards for Internet On-line Counseling as ~~revised~~ approved by the American counseling association ~~of counseling and development~~ governing ~~counsel, April 1997)~~ council in 1999 as its code of ethics for the practice of counseling. A copy ~~of the ethical standards of the American counseling association~~ may be obtained from the board.

History: Effective February 1, 1995; amended effective February 1, 1998; December 1, 2001.
General Authority: NDCC 28-32-02, 43-47-03
Law Implemented: NDCC 43-47-03