# NORTH DAKOTA ADMINISTRATIVE CODE

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# TITLE 7

# AGRICULTURE COMMISSIONER

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## ARTICLE 7-03.2

## DAIRY DIVISION


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## CHAPTER 7-03.2-01
## DEFINITIONS


Section
7-03.2-01-01 Definitions


**7-03.2-01-01. Definitions.** As used in this article, unless the context requires otherwise:

1. “Commissioner” means the North Dakota agriculture commissioner or the North Dakota agriculture commissioner’s designee or representative.

2. “Environmental protection agency” means the United States environmental protection agency.

3. “Food and drug administration” means the United States food and drug administration.

4. “State department of health” means the North Dakota state department of health.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-55.1

# CHAPTER 7-03.2-02
# LICENSE TO HAUL, SAMPLE, AND TEST

Section
7-03.2-02-01 New Licenses
7-03.2-02-02 Relicensing
7-03.2-02-03 Training

**7-03.2-02-01. New licenses.** All samplers, milk haulers, and testers must have a license from the commissioner. All applicants for a sampler and tester license must successfully complete an examination conducted by a certified individual employed by the commissioner or the state department of health, or other individual approved by the commissioner. Milk haulers must also comply with the requirements of chapter 7-03.2-13.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-12, 4-30-18

**7-03.2-02-02. Relicensing.** To be relicensed, samplers, milk haulers, and testers must hold a current license and take any examinations or retraining the commissioner requires.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-12, 4-30-38.1

**7-03.2-02-03. Training.** All licensed samplers and milk haulers must attend a training session at least once every two years. The request for training is the responsibility of the sampler or milk hauler. Training must be provided by the commissioner.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-12, 4-30-38.1

## CHAPTER 7-03.2-03
## REQUIREMENTS FOR SAMPLING AND TESTING

Section


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**7-03.2-03-01. General requirements.** All tests performed by testers must conform with the requirements in the standard methods. The results of such tests must be retained for one year and must be available to the commissioner upon request.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18, 4-30-37

**7-03.2-03-02. Laboratories.** All laboratories used for sampling and testing milk and milk products must meet all of the requirements for grade A laboratories in the pasteurized milk ordinance. All manufacturing grade laboratories used for sampling and testing milk and milk products must meet all regulations imposed by the United States department of agriculture. On a case-by-case basis and only for good cause, the commissioner may waive the requirements of this section if the commissioner imposes substitute requirements that are substantially equivalent to those required above.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18

**7-03.2-03-03. Universal sampling.** A universal sample must be collected every time milk is picked up at the farm. This sample must be aseptically collected and may be used for all tests required by the commissioner. Before a sample is collected, the milk in the tank from which the sample is to be taken must be agitated to ensure that the sample is representative of the tank's contents.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18

**7-03.2-03-04. Sample reporting - Records.**

1. The results of all raw milk testing done for regulatory purposes by industry laboratories must be reported to the commissioner. When a test shows the presence of adulterants in these samples, the test results must be reported immediately to the commissioner by telephone or facsimile with a hard copy of the results immediately sent to the commissioner. All tests above the maximum levels established by law must be reported to the commissioner weekly.

2. Records on sampling, testing, or grading of milk or cream created to comply with article 7-03.2 and North Dakota Century Code chapter 4-30 to establish producer pay levels must be retained and available to the commissioner for twelve months. These records must include the following:

   a. Producer identification number.

   b. Date of sampling, testing, or grading.

   c. Type of sampling, testing, or grading procedure used.

   d. Results of sampling, testing, or grading.

   e. Name of licensed tester, grader, or sampler conducting the procedure.

3. When the commissioner is investigating a complaint, the plant must give the commissioner access to all quality records that the commissioner requests.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18, 4-30-37

**7-03.2-03-05. Butterfat and protein composite sampling.** A composite sample used to test butterfat and protein must consist of a minimum of twenty milliliters made up of a representative sample from each delivery of milk or cream to the plant. A minimum of ten milliliters of milk from each delivery must be included in the composite sample. The composite sample must be maintained at a temperature of thirty-two to forty degrees Fahrenheit [0 to 4.4 degrees Celsius]. A composite sample may not be retained for more than fifteen days and must be tested within three days after the last addition. A chemical preservative must be added to maintain the integrity of the sample. Approval for the type and concentration of the preservative must be given by the commissioner upon request. If a composite testing program is being used for butterfat or protein determination, a minimum of two deliveries is required. A log is required on all composite samples maintained and available to the commissioner for twelve months. This log must list all of the following:

1. Date of the test.

2. Pickup weight of milk.

3. Producer's identification.

4. Protein or butterfat, or both, result for that composite sample.

5. Name of licensed tester performing the test.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18

**7-03.2-03-06. Farm tank calibration disputes.** When a dispute exists between the buyer and seller of raw milk as to the amount of milk being removed from farm bulk milk tanks, the buyer or seller may contact the commissioner who may review the matter and supply a recommended resolution to the buyer and seller.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18

**7-03.2-03-07. Sampling equipment.** All sampling equipment must comply with requirements in the standard methods. Certified thermometers must be used to take samples. Certified thermometers must be accurate within two degrees Fahrenheit [0.55 degree Celsius]. Their accuracy must be checked once during a six-month period at a calibration temperature of forty-two to forty-five degrees Fahrenheit [5.5 degrees to 7.22 degrees Celsius]. The thermometer must be calibrated by a certified mercury actuated thermometer. Certification must be obtained at a certified laboratory by a trained analyst approved by the commissioner. The analyst must maintain a log of the results of each thermometer certified. The log must contain the same information recorded on the thermometer and must show the certification history of all thermometers for which the analyst is responsible for one year. The following must be listed on certified thermometers:

1. Initials of the person calibrating the thermometer.

2. The date of calibration.

3. The date the calibration expires.

4. The thermometer owner's name or the thermometer number.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18

**7-03.2-03-08. Farm samplers.** Individuals licensed to sample milk at farms shall follow the procedures in the North Dakota milk hauler and sampler manual, issued by the commissioner.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18

**7-03.2-03-09. Plant samplers.**

1. Plant storage tanks used for storing raw milk without sampling cocks must be sampled using the procedures described in the North Dakota milk hauler and sampler manual, issued by the commissioner.

2. Samples taken from plant storage tanks with sampling cocks must use the following procedures:

   a. Rinse the area around the sample cock with warm water and clean if needed.

   b. Wash and dry hands.

   c. Sanitize sample cock with an approved sanitizer or equivalent, using a minimum contact time of sixty seconds.

   d. Purge sample cock by discarding enough milk to remove any excess chlorine solution.

   e. Label two sample containers with the following information:

      (1) Plant name.

      (2) Date.

      (3) Time.

      (4) Temperature.

      (5) Sampler name or initials.

      (6) Tank or silo identification.

      (7) The sample container to be used for the temperature control must also have "T.C." noted on it.

   f. Aseptically remove the top of the bag or cap cover of the sample container marked "T.C." Fill the sample container three-quarters full, close, and place immediately in a refrigerated sample case with a water-ice mixture capable of keeping the sample at a

temperature of thirty-two through forty degrees Fahrenheit [0 through 4.4 degrees Celsius].

g. Using the certified thermometer, obtain the temperature of the milk in the sample container marked "T.C." Write this temperature on both sample containers.

h. Aseptically remove the top of the bag or cap of the second sample container and obtain a sample. Fill the sample container three-quarters full. Close and place immediately in the refrigerated sample case.

i. Rinse off all excess milk from the sample cock and storage tank or silo.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18

**7-03.2-03-10. Finished product sampling procedures.**

1. All finished product that is to be sampled or tested for regulatory purposes must be collected by the commissioner. Samples must be collected randomly and the older code date must be selected before a more recent code date.

2. Finished product chosen for sampling must be stored in a refrigerated sample container that maintains the samples at thirty-two to forty degrees Fahrenheit [0 to 4.4 degrees Celsius]. A temperature control sample must be selected for each area or cooler where finished milk product is stored. The temperature control must be opened and a temperature obtained using a certified thermometer. The temperature control must be closed and sealed to prevent leakage during transport. Samples must be taken at the plant of origin.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-18

**7-03.2-03-11. Adulterants.**

1. **Drug testing.**

   a. Raw milk. Prior to processing, the processor must test all bulk milk pickup tankers for the presence of beta lactam drug residues and for other residues as determined necessary by the commissioner. Test methods will be those approved by the association of official analytical chemists or the food and drug administration. A positive test on the commingled sample requires confirmation testing for

drug residues of all individual producer samples making up the bulk pickup tanker. Bulk milk tankers testing positive must be reported to the commissioner immediately. This report must include the tests used, volume of milk contaminated, how the milk was disposed of, and which producer caused the positive residue. All milk sample residue results must be recorded and retained for examination by the commissioner for twelve months.

b. Bulk load rejected. If a bulk load of milk tests positive for a drug residue, the processor shall reject the entire bulk load. The rejected bulk load may not be used for human food.

c. Processor's loss - investigation. If a processor sustains a monetary loss because a bulk load of milk is rejected, the processor may file a complaint with the commissioner. The commissioner may investigate the complaint and may issue a report on the amount of monetary loss suffered by the processor and on the responsibility for the rejected load and for the processor's monetary loss.

d. Followup testing. If a bulk load of milk tests positive for drug residue, the processor shall immediately notify the commissioner and suspend further pick up of milk from the producer whose milk contaminated the bulk load until followup tests of that producer's milk test negative for drug residues. The dairy processor must perform these followup tests.

e. Testing bulk loads. In addition to performing routine beta lactam tests, a processor shall randomly test bulk milk deliveries for other drug residues as required by the commissioner. The drug testing program shall include milk from each producer in at least four separate months during any consecutive six-month period.

f. Finished product. All finished milk products must be free of antibiotics. Raw milk contaminated with antibiotics may not be used in processing finished milk products. All manufacturing grade finished milk products must be tested as determined by the commissioner. These products include fluid and cultured products, butter, cheese, and other products so designated by the commissioner.

2. **Drug residue and other substances.** A person may not sell or offer for sale milk that contains drug residues or other chemical substances in amounts above the tolerances set in the food and drug administration's Memorandum of Information No. M-I-05-5, dated September 27, 2005, and in title 21, Code of Federal Regulations, parts 530 and 556. These levels are merely guidelines. Milk with drug residues or other chemical substances below these tolerances is not necessarily unadulterated or otherwise acceptable milk, and selling or offering to sell such milk may be subject to penalty and other regulatory action by the commissioner.

a. When a producer has shipped milk that tests positive for residue, the producer's farm license must be suspended until a sample of the producer's milk tests negative.

b. When a producer has shipped milk that tests positive for residue three times in a twelve-month period, the producer's farm license may be revoked if the commissioner's investigation warrants such action.

c. The commissioner will complete a followup inspection when a producer's milk tests positive for residue.

3. **Pesticides.** Milk containing any pesticides or chemical contamination exceeding food and drug administration or environmental protection agency standards for safe food may not be offered for sale.

4. **Added water.** Milk may not contain added water. Any milk that tests under .530 degrees Horvet using the cryoscope thermistor test may not be offered for sale.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-02, 4-30-18, 4-30-31, 4-30-38, 4-30-40

## CHAPTER 7-03.2-04
## LICENSING PROCEDURES FOR DAIRY FARMS

Section


7-03.2-04-01 General Requirements for Licensing Dairy Farms
7-03.2-04-02 Special Requirements for Licensing Dairy Farms
7-03.2-04-03 Denial of Licensure and Appeal
7-03.2-04-04 Temporary Facilities' License for Selling Raw Milk
7-03.2-04-05 Grade A Farms - Loss of Status - Inspection - Access


**7-03.2-04-01. General requirements for licensing dairy farms.**

1. All dairy farms wishing to sell milk must apply for a farm license. No farm may sell milk without a license.

2. Application for a license must be filed with the commissioner. Soon after receiving the application the commissioner shall inspect the farm and its facilities and premises.

3. A set of plans containing information on the dairy farm, milking facility, and milking equipment must be submitted to the commissioner for new dairy farms and prior to major changes in existing facilities. The plans must be provided by the dairy producer and approved by the commissioner prior to licensure and prior to starting any construction.

4. A facility inspection must be conducted and a water sample taken as a licensing requirement. Satisfactory results from both these items will result in the posting of an inspection sheet, which certifies that the facility can sell milk in North Dakota.

5. The inspection sheet must be prominently posted in the milkhouse and is part of the record in all administrative proceedings involving compliance with North Dakota Century Code chapter 4-30 and rules enacted under it.

6. The commissioner will license dairy farms either as:

   a. Grade A, which is a farm that is licensed to meet production practices required by North Dakota Century Code section 4-30-36; or

   b. Manufacturing grade, which is a farm that is licensed to meet production requirements required by North Dakota Century Code section 4-30-27.

7. Licensure continues unless suspended or revoked and is not transferable.

8. A dairy farm temporarily not in use during a normally scheduled inspection is required to be relicensed prior to starting raw milk production.

9. All licensed farms will be assigned a producer number by the commissioner. This number must be used by the producer, bulk hauler, and plant when communicating with the dairy commissioner.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27, 4-30-28, 4-30-36

**7-03.2-04-02. Special requirements for licensing dairy farms.**

1. **Grade A milk farm.** To be licensed as a grade A milk farm, the farm must satisfy the following:

   a. The farm, including its water supply and all facilities, must meet all pasteurized milk ordinance requirements.

   b. The water supply must meet the requirements of the North Dakota board of water well contractors and state department of health, or the water supply must be approved for municipal or rural water use by the state department of health.

   c. Properly constructed wells must be located at least fifty feet [15.24 meters] from privy pits, cesspools, septic tanks, control pits, absorption fields, sewers, barnyards, and feedlots, and from the high water marks of lakes, streams, sloughs, ponds, etc. Fifty feet [15.24 meters] is the distance requirement with favorable soil conditions. The commissioner may require more than fifty feet [15.24 meters] when soil conditions are unknown or unfavorable, and when required by the presence of contaminants or toxic chemical wastes in the area.

   d. Wells must be at least ten feet [3.01 meters] from basements.

   e. Wells must be at least one hundred fifty feet [45.72 meters] from underground manure storage, chemical or fertilizer storage, or chemical preparation area.

   f. Wells must be at least ten feet [3.01 meters] from hydrants.

   g. Well sites may not be subject to flooding and should be graded to facilitate the rapid drainage of surface water away from the well. The area must be filled, if necessary, graded, and maintained to prevent the accumulation or retention of surface water within fifty feet [15.24 meters] of the well.

h. For a well on a hillside, intercepting ditches must be constructed on the uphill side of the well to keep runoff at least fifty feet [15.24 meters] away from the well.

i. The casing or pitless unit for all ground water sources must project not less than twelve inches [30.48 centimeters] above the final ground elevation, the well cover slab, or pumphouse floor.

j. Pit wells, buried well seals, and sand point wells are unacceptable. If, however, a pit well is presently being used on an existing permitted farm, it may continue to be used until there is a need and intention to repair or upgrade it, and, if so, then the pit well must be eliminated from the dairy operation.

k. The farm bulk tank must be empty at the time of licensing.

l. The hoseport must be installed in an exterior milkhouse wall.

m. The hoseport slab must be at least a six-foot by six-foot [1.83-meter by 1.83-meter] cement slab centered under the hoseport.

n. The milkhouse must have a direct door to the outdoors. Haulers must not have to go into milking area or animal housing area to access the milkhouse.

o. All bulk tanks must have an accurate working thermometer.

p. Neither light fixtures nor vents may be placed over bulk tanks.

q. Handwashing facilities must be in the milkhouse. Hand sinks must be of lavatory fixture style and at least twenty-four inches [60.96 centimeters] away from wash vats or have a splash board of sufficient size to prevent contaminating the wash vat. Wash vats must be stainless steel and have two compartments.

r. Light must be provided to properly inspect the interior of bulk tanks.

s. Livestock or fowl may not have access to truck approach (driveway) or loading area.

t. Hot water heater capacity must be adequate to properly clean equipment.

u. There must be adequate backflow preventors upstream from tube, plate coolers and heat exchangers to protect the milkhouse and water supply. Backflow preventors are also required downstream of tubeplate coolers, and heat exchangers unless there is a physical

break downstream. The physical break must be at least two times the diameter of the discharge line.

v. Properly mounted and installed 36A and N36 vacuum relief valves are required on power washers and booster pumps.

w. All equipment must meet 3A standards and practices.

x. All milk to be offered for sale must be maintained at forty-five degrees Fahrenheit [7.22 Celsius] or less.

2. **Manufacturing grade milk farm.** Manufacturing grade milk farms must meet all rules of the United States department of agriculture.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-28, 4-30-29

**7-03.2-04-03. Denial of license and appeal.**

1. Should the inspection determine that deficiencies exist that prevent licensing, the farm may not be licensed.

2. The producer shall correct all deficiencies before requesting a reinspection.

3. A producer denied a license may appeal that decision to the commissioner within thirty days of the denial, by requesting, in writing, a hearing. The commissioner shall convene a hearing as soon as possible.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-29-03, 4-29-04, 4-30-55.1
**Law Implemented:** NDCC 4-30-28

**7-03.2-04-04. Temporary facilities' license for selling raw milk.**

1. Application must be made to the commissioner to license temporary facilities for dairy shows, fairs, etc.

2. Temporary facilities must comply with all construction requirements in article 7-03.2 and in North Dakota Century Code chapter 4-30 for farm facilities offering raw milk for sale. Lactating dairy animals must never be housed with fowl, swine, or other potential carriers of milk-borne illnesses.

3. An onsite facility inspection must be conducted by the commissioner prior to milk sales. If a temporary permit is issued, the permit will be the commissioner's inspection sheet, which the licensee must post in

a place at the licensed facility to be readily viewed by the public. The permit duration will be set by the commissioner.

4. All milk offered for sale from facilities with temporary permits must be screened by the licensee for inhibitory substances by use of the Delvo P or other tests accepted by the commissioner. The person administering the test must be a licensed tester.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27, 4-30-36

**7-03.2-04-05. Grade A farms – Loss of status – Inspection - Access.**

1. If a grade A farm has three repeat violations that concern the same inspection item, or if the farm scores seventy-five or below in an inspection, it will be downgraded to manufacturing grade status. The commissioner shall notify the milk plant, the milk hauler, and the producer of the status change.

2. A grade A farm in violation of equipment cleaning , drugs, temperature, and other requirements established to protect the public from serious health risks will be reinspected not before three days but before twenty-one days.

3. If access to a grade A farm is denied to persons seeking to undertake an inspection, federal check rating, an interstate milk survey, or any state inspection, then the farm will be immediately downgraded to manufacturing grade status and will lose its grade A status.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27, 4-30-28, 4-30-36

## CHAPTER 7-03.2-05
## MANUFACTURING FARM REGULATIONS

Section


7-03.2-05-01 Herd Health
7-03.2-05-02 Quality Standards
7-03.2-05-03 Water Supply
7-03.2-05-04 Milk Truck Approach - Hoseport Slab - Port Opening
7-03.2-05-05 Waste
7-03.2-05-06 Federal Requirements
7-03.2-05-07 Pesticides and Medicines
7-03.2-05-08 Bulk Milk - Tank - Conversion Table - Temperature
7-03.2-05-09 Premises Cleanliness
7-03.2-05-10 Milking Procedures
7-03.2-05-11 Farm Inspection Procedures and Enforcement


**7-03.2-05-01. Herd health.** Milk offered for sale must be obtained from healthy cows.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27, 4-30-40

**7-03.2-05-02. Quality standards.**

1. Milk offered for sale must meet United States department of agriculture regulations.

2. The commissioner will place a producer's raw milk under warning when:

   a. Two of the last four bacteria counts exceed 500,000 cells/ml. No sooner than three days, nor more than twenty-one days, after the commissioner issues the warning, another milk sample must be taken and tested. If the result is more than 500,000 cells/ml, the producer's milk must be excluded from the market. To regain access to the market the farm must pass an inspection by the commissioner, during which the bulk milk tank must be empty, and the farm's milk must be sampled and tested under and must meet conditions set by the commissioner. If the result of this test is 500,000 cells/ml or less, a temporary permit will be issued. If a temporary permit is issued, three milk samples must be taken within twenty-one days after the permit is issued. No more than two samples may be taken within any seven-day period. If the bacteria count of all three samples is 500,000 cells/ml or less, the producer will again have full status for manufacturing grade milk.

   b. Two out of the last four monthly somatic cell counts exceed 750,000 cells/ml. No sooner than three days, nor more than twenty-one days, after the commissioner issues the warning

another milk sample must be taken and tested. If the result is more than 750,000 cells/ml, the producer's milk must be excluded from the market. To regain access to the market the farm's milk must be sampled and tested and must meet conditions set by the commissioner. If the result of this test is 750,000 cells/ml or less, a temporary permit will be issued. If a temporary permit is issued, three milk samples must be taken within twenty-one days after the permit is issued. No more than two samples may be taken within any seven-day period. If the somatic count of all three samples is 750,000 cells/ml or less, the producer will again have full status for manufacturing grade milk.

c. The sediment content exceeds regulations set by United States department of agriculture. No sooner than three days, nor more than twenty-one days, after the commissioner issues the warning another milk sample must be taken and tested. If the result shows that the sediment content does not exceed regulations set by the United States department of agriculture, the warning will be withdrawn. If the result shows that the sediment content exceeds regulations set by the United States department of agriculture, the milk must be excluded from the market. To regain access to the market the producer's farm must pass an inspection by the commissioner and the farm's milk must be sampled and tested under conditions set by the commissioner and the result must show that the milk satisfies standards set in the pasteurized milk ordinance and regulations set by the United States department of agriculture.

3. A farm license will be suspended if the farm scores below eighty on three consecutive farm inspections. The commissioner will reinstate a license when conditions leading to the suspension have been corrected by evidence of either test results or a satisfactory farm inspection.

4. Milk offered for sale must be tested monthly to determine sediment content. The sediment standard must not exceed fifty-hundredths milligrams. All sediment tests must be by the mixed sample method, unless otherwise approved by the commissioner.

5. The volume of milk in the bulk tank after the first milking must be sufficient to ensure adequate agitation of the milk. Failure to produce adequate volumes on the first milking may result in suspension of a farm's license to sell raw milk.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27, 4-30-31

**7-03.2-05-03. Water supply.**

1. The farm's water supply must be properly located, protected, and operated and must be an ample supply and safe for cleaning utensils and equipment. Rural farm water supplies approved by the state department of health are acceptable. Wells constructed in compliance with state board of water well contractors and tested every three years by an approved laboratory and found to be satisfactory are acceptable. Other water supplies approved by the commissioner and tested annually and found to be satisfactory are acceptable. All water sources must be tested following repairs or other disruptions to the water system and must be found satisfactory. All new water supplies to dairy farms must comply with either the state department of health requirements for rural water or the state board of water well contractors requirements for well construction.

2. Handwashing facilities with soap, individual sanitary towels, and hot and cold water under pressure must be provided.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

**7-03.2-05-04. Milk truck approach - Hoseport slab - Port opening.** The milk truck approach to the milk loading area must prevent excess mud and allow easy access to the milkroom. Farm animals must not have free access to the milk loading area. The hoseport slab and milk loading area must be kept clean. The hoseport slab must be constructed of concrete or other impervious material and centered under the port opening through which milk is transferred from the bulk tank to the milk truck. New hoseport slabs must be at a minimum six feet by six feet [1.83 meters by 1.83 meters]. The port opening must be closed when not in use.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

**7-03.2-05-05. Waste.** All toilet wastes on the farm and all milkhouse and milkroom wastes must be disposed of in a manner that will not pollute the soil surface, contaminate any water supply, or be exposed to insects.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

**7-03.2-05-06. Federal requirements.** Farms selling manufacturing grade milk must comply with United States department of agriculture rules governing such facilities.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

**7-03.2-05-07. Pesticides and medicines.** Only pesticides approved for use in the milkroom with an environmental protection agency number may be stored in the milkroom and when used must be used in accordance with label instructions. Automatic pesticide dispensers are allowed if properly installed and used with approved pesticides. Antibiotics and other medicines may be stored in the milkroom if stored in a manner that ensures that neither the milk supply nor milk contact equipment is contaminated.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

**7-03.2-05-08. Bulk milk - Tank - Conversion table - Temperature.** The bulk milk tank must be equipped with an approved milk measuring device. A conversion table to determine pounds [kilograms] must be in the milkroom. Milk above forty-five degrees Fahrenheit [7.22 degrees Celsius] must not be offered for sale or transported off the farm.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

**7-03.2-05-09. Premises cleanliness.** The farm must be kept clean. Manure must be removed daily from the milking parlor or stored in a way that prevents access by cows. Stacked or piled manure and manure packs in housing facilities must be spread prior to fly season each year. The yard or loafing area must be of ample size to prevent overcrowding, must be drained to prevent standing water pools, and must be kept clean.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

**7-03.2-05-10. Milking procedures.** All milking procedures must comply with United States department of agriculture regulations.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

**7-03.2-05-11. Farm inspection procedures and enforcement.**

1. Farms under warning for cleaning violations, major drug violations, or cooling equipment problems will be inspected within twenty-one days.

2. Items for which the commissioner has established a compliance deadline are exempted from further action until the deadline has expired.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27, 4-30-28

# CHAPTER 7-03.2-06
# CHANGING THE MILK BUYER

Section
7-03.2-06-01 Transfer Procedures

**7-03.2-06-01. Transfer procedures.**

1. A dairy producer who wants to contract with a new milk buyer shall apply to the commissioner for authority to do so. The application must be on forms provided by the commissioner.

2. Upon receipt of an application, the commissioner shall examine the applicant's inspection and milk quality records. If the records indicate that the applicant meets minimum milk quality standards and is under no suspension or suspension warning, the commissioner shall immediately approve the application and mail a copy to the applicant and the buyers involved. Should the applicant's records leave doubt about whether minimum standards are met, the commissioner shall immediately order a milk sample be taken or an inspection of the dairy facility, or both, to determine compliance. If the inspection and milk quality tests conclude that the applicant meets minimum standards, the commissioner shall immediately approve the transfer. The transfer takes effect on the date the commissioner approves it or on another date the commissioner sets.

3. The commissioner shall approve or disapprove an application in writing, within seven days. Additional time may be taken if the commissioner requires a farm inspection or testing a milk sample.

4. Upon the applicant's written request, which must be submitted within thirty days of the denial of a transfer request, the commissioner shall promptly convene a hearing to determine whether the denial was proper.

5. If an applicant wishes to retain the applicant's current milk buyer before the approved transfer date, the applicant may ask the commissioner to rescind the transfer. The applicant must notify the buyers involved that the transfer was rescinded.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-32

## CHAPTER 7-03.2-07
## MILK AND MILK PRODUCTS STANDARDS

Section
7-03.2-07-01 Chemical, Physical, Bacteriological, and Temperature Standards
7-03.2-07-02 Enforcement Procedures

**7-03.2-07-01. Chemical, physical, bacteriological, and temperature standards.** All milk and milk products must meet the chemical, physical, bacteriological, and temperature standards established by the United States department of agriculture regulations and by the pasteurized milk ordinance.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-35, 4-30-36

**7-03.2-07-02. Enforcement procedures.**

1. Whenever three of the last five consecutive bacteria, temperature, or coliform counts exceed the standards of the pasteurized milk ordinance or United States department of agriculture regulations, the commissioner will suspend the license of the plant processing the product.

2. Whenever any phosphatase test is positive, the commissioner shall conduct an investigation to determine the cause and the product in question may not be offered for sale until the cause is determined and eliminated.

3. Whenever any drug or pesticide test results in a level exceeding the limits established by the food and drug administration or environmental protection agency, the product in question must be removed from the market and the commissioner shall conduct an investigation to determine the cause. The milk product in question may not be offered for sale until the cause is determined and eliminated.

4. Raw milk cheese may not be processed or sold in North Dakota. All milk to be used for cheese processing must be heat- treated or pasteurized. The heat treatment must be at least one hundred forty-seven degrees Fahrenheit [63.89 degrees Celsius] for twenty-one seconds, or at least one hundred fifty-three degrees Fahrenheit [67.22 degrees Celsius] for fifteen seconds.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-35, 4-30-36, 4-30-56

# CHAPTER 7-03.2-08
# COMPOSITION STANDARDS FOR MILK PRODUCTS

Section
7-03.2-08-01 Composition Standards for Milk Products

**7-03.2-08-01. Composition standards for milk products.** All pasteurized milk ordinance-defined milk and milk products must satisfy the composition standards set by the pasteurized milk ordinance and food bearing standardized food names must comply with the Code of Federal Regulations standard.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-35, 4-30-36

## CHAPTER 7-03.2-09
## FROZEN DESSERTS


| Section | |
|---|---|
| 7-03.2-09-01 | Frozen Desserts - Manufacturers and Processors Regulations |
| 7-03.2-09-02 | Microbiological Requirements for Ice Cream, Ice Milk, Ice Cream Mix, and Frozen Yogurt |
| 7-03.2-09-03 | Resampling |


**7-03.2-09-01. Frozen desserts - Manufacturers and processors regulations.**

1. For the purposes of this chapter, frozen desserts include ice cream, ice milk, sherbet, soft serve, frozen yogurt, and any frozen dessert or ice cream mix containing dairy products.

2. A license from the commissioner is required for any frozen dessert processor that packages, freezes, or adds flavors to ice cream mix. Establishments taking the product directly from the mix freezer and delivering it directly to the ultimate consumer are exempt from licensing.

3. All frozen dessert processors must be inspected once every three months by the commissioner.

4. All new equipment used by frozen dessert processors must comply with 3A standards or other standards acceptable to the commissioner. Modifications of plant processes for manufacturing frozen desserts must be submitted to the commissioner for approval prior to installation or construction.

5. All raw milk and dairy ingredients used in processing frozen desserts must be pasteurized and must originate from plants approved by the United States department of agriculture, the food and drug administration, or the commissioner.

6. Sanitary requirements, at a minimum, must meet United States department of agriculture regulations for manufacturing frozen desserts.

7. Four samples within a six-month period must be collected by the commissioner from each frozen dessert processor.

8. Samples must be handled in accordance with the standard methods. Samples must be tested at laboratories approved by the commissioner.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-02, 4-30-33, 4-30-35, 4-30-36

**7-03.2-09-02. Microbiological requirements for ice cream, ice milk, ice cream mix, and frozen yogurt.**

1. The United States department of agriculture regulations that set microbiological requirements for frozen desserts apply to ice cream, ice milk, ice cream mix, and frozen yogurt.

2. All milk, when delivered to a plant to be used in making ice cream, ice milk, ice cream mix, or frozen yogurt, must have a temperature of forty-five degrees Fahrenheit [7.22 degrees Celsius] or lower. If the delivered milk is from a single producer, it must not exceed five hundred thousand per milliliter standard plate count. If the delivered milk is commingled, it must not exceed one million per milliliter standard plate count.

3. All cream delivered to a plant to be used in making ice cream, ice milk, ice cream mix, or frozen yogurt must have a temperature of forty-five degrees Fahrenheit [7.22 degrees Celsius] or lower. All delivered cream must not exceed eight hundred thousand per milliliter standard plate count.

4. All dry dairy ingredients to be used in making ice cream, ice milk, ice cream mix, or frozen yogurt must meet the manufacturing standards set by United States department of agriculture regulations.

5. All ice cream, ice milk, ice cream mix, and frozen yogurt products must meet the following phosphatase and coliform requirements:

   a. Phosphatase. The phenol value of a product may be no greater than the minimum specified for the product as determined by the phosphatase test in the standard methods, or other tests approved by the commissioner.

   b. Coliform.

      (1) In plain ice cream, ice milk, ice cream mix, and frozen yogurt products, the coliform may not exceed ten per milliliter. Further, these products must not exceed twenty thousand per milliliter standard plate count.

      (2) In flavored ice cream, ice milk, ice cream mix, and yogurt products, the coliform may not be more than twenty per milliliter. Further, these products must not exceed twenty thousand per milliliter standard plate count.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-33, 4-30-35, 4-30-36

**7-03.2-09-03. Resampling.** When a sample exceeds the microbiological requirements, the licensed operator must be notified in writing. An additional sample must be taken in not less than three days or more than twenty-one days from the notification. When two samples out of four consecutive samples are not in compliance, a warning must be sent. An inspection must be made at this time to determine sanitary conditions. When three out of five consecutive samples are not in compliance, sale of the product must be stopped until the test results are in compliance.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-29-03, 4-29-04, 4-30-55.1
**Law Implemented:** NDCC 4-30-33, 4-30-35, 4-30-36

## CHAPTER 7-03.2-10
## INSPECTION REQUIREMENTS FOR DAIRY MANUFACTURING AND PROCESSING PLANTS

Section
7-03.2-10-01 Premises

**7-03.2-10-01. Premises.** Dairy processing plants must comply with United States department of agriculture regulations for approved dairy plants and regulations for grades of dairy products and with appendix H of the pasteurized milk ordinance.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-34

## CHAPTER 7-03.2-11
## INSPECTION CRITERIA FOR GRADE A PLANTS

Section
7-03.2-11-01 Inspection Criteria

**7-03.2-11-01. Inspection criteria.** All grade A milk must be processed according to the requirements of the pasteurized milk ordinance.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-36

## CHAPTER 7-03.2-12
## TRANSPORTATION OF MILK AND CREAM FOR MANUFACTURING, PROCESSING, OR BOTTLING PURPOSES

Section
7-03.2-12-01 Licensing
7-03.2-12-02 Equipment and Vehicles
7-03.2-12-03 Raw Milk Pickup
7-03.2-12-04 Pup Trailers - Two-Compartment Tankers
7-03.2-12-05 Washing Trucks
7-03.2-12-06 Topping Off - Emptying Farm Bulk Tank

**7-03.2-12-01. Licensing.** All persons owning or operating a truck or other vehicle involved in transporting milk and cream for manufacturing purposes must be licensed by the commissioner.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-02, 4-30-12, 4-30-38.1

**7-03.2-12-02. Equipment and vehicles.** The maximum amount of time between pickup of milk on the farm is ninety-six hours. All equipment used to transport milk or cream must conform to 3A standards, or other standards acceptable to the commissioner. Equipment not meeting 3A standards and not otherwise having the commissioner's approval must be sealed or tagged by the commissioner and may not be used for storing and transporting milk and milk products. Vehicles used for transporting milk or milk products may not be used for transporting other products, unless approved by the commissioner.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-38

**7-03.2-12-03. Raw milk pickup.**

1. Raw milk picked up on the farm must be stored in containers meeting all the following requirements:

   a. Comply with 3A standards, or other standards approved by the commissioner.

   b. Able to agitate to obtain a universal sample.

   c. Able to hold milk at a temperature between thirty-two to forty-five degrees Fahrenheit [0 to 7.22 degrees Celsius].

2. Only raw milk stored on the farm in bulk tanks approved by the commissioner may be picked up. Milk stored in containers not

complying with this section may not be added to milk stored in a container meeting the requirements of this section.

3. Filter bowls or open bowl strainers with fiber filters must comply with 3A standards. Only approved in-line filtering devices may be used to transfer milk from a farm bulk tank to a farm bulk truck. These devices must be stored in a sanitary manner.

4. During transfer of all milk or milk products from farm bulk trucks or tankers, a filter is required for any air inlet vent when the transfer occurs out-of-doors or in an area not completely enclosed.

5. Transfer of milk and milk products between trucks or tankers must be made from valve to valve with adequate filter protection for air inlet vent.

6. Only milk stored at forty-five degrees Fahrenheit [7.22 degrees Celsius] or below may be picked up at the farm.

7. Milk may only be picked up from farms that have posted a valid license issued by the commissioner.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-38

**7-03.2-12-04. Pup trailers - Two-compartment tankers.** When pup trailers are used in hauling milk and milk products, the connecting pipeline between the main tanker and pup trailer must be kept free of milk or milk products during transport. Any milk retained in the connecting pipeline must be disposed of and not transferred to plant storage silos or tanks. These connecting pipelines or hoses must be cleaned and sanitized between each use. Two-compartment tankers must carry the same grade product in each compartment unless all the milk is used for the lowest grade.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-38

**7-03.2-12-05. Washing trucks.**

1. a. All tankers and farm bulk trucks used for transporting raw milk from the farm to the plant must be washed and sanitized at the end of each day's use. A record of this cleaning must be kept and may consist of a mechanical recording chart, a wash log, or any other approved method that contains the following information:

    (1) Truck identification, with the state identification number if applicable.

(2) Name and location of wash station.

(3) Date and time of washing.

(4) Date and time of sanitizing.

(5) Type of sanitizer.

(6) Complete name of the person who did the washing and sanitizing.

b. All items such as valves and milk pumps that cannot be cleaned in place must be manually cleaned and sanitized at the end of each day's use.

2. a. All tankers and farm bulk trucks washed and sanitized outside of North Dakota require a seal on the outlet valve and wash tag containing the following information:

(1) Truck identification, with the state identification number if applicable.

(2) Name and location of wash station.

(3) Date and time of washing.

(4) Date and time of sanitizing.

(5) Type of sanitizer.

(6) Complete name of the person who did the washing and sanitizing.

b. All milk transported in tankers or farm bulk trucks that are washed out of state and do not have the required seal and wash tag must be diverted to nongrade A uses.

3. If milk is held in tankers or farm bulk trucks overnight, the milk may not exceed forty-five degrees Fahrenheit [7.22 degrees Celsius].

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-38

**7-03.2-12-06. Topping off - Emptying farm bulk tank.** Milk haulers must completely empty a farm bulk tank at every pickup. If this is not possible, the milk remaining in the farm bulk tank must be picked up before the next milking. Failure to

completely empty the farm bulk tank prior to the next milking is defined as "topping off". It is a violation of this section to top off any farm bulk tank.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-38

## CHAPTER 7-03.2-13
## MILK HAULERS LICENSING


| Section | |
|---|---|
| 7-03.2-13-01 | License Requirements |
| 7-03.2-13-02 | Training |
| 7-03.2-13-03 | Violations |


**7-03.2-13-01. License requirements.** All owners of tankers and farm bulk trucks must be licensed by the commissioner as milk haulers. The following items must be complied with to obtain a license:

1. The outside of vehicles hauling milk must be identified with the owner's name, address, and identification number. This information must be in letters of such height making them easy to read from a distance of one hundred feet.

2. Vehicles hauling milk must comply with 3A standards for unrefrigerated tanks storing milk and milk products.

3. The license must be renewed annually.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-02, 4-30-12, 4-30-38.1

**7-03.2-13-02. Training.** The milk hauler must train new employees, samplers, and haulers, and must schedule with the commissioner annual training sessions for all employees.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-38.1

**7-03.2-13-03. Violations.** The milk hauler is responsible for the acts of any employee who violates the requirements of this article.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-38.1

## CHAPTER 7-03.2-14
## TRANSPORTATION OF PROCESSED AND MANUFACTURED PRODUCTS

Section
7-03.2-14-01 License
7-03.2-14-02 Vehicle Requirements
7-03.2-14-03 Outdated Products

**7-03.2-14-01. License.** All persons who transport processed and manufactured dairy products from the processing plant for retail sale or sale directly to the consumer must be licensed by the commissioner.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-02

**7-03.2-14-02. Vehicle requirements.** All vehicles used to transport dairy products must comply with the following:

1. A temperature of forty-one degrees Fahrenheit [5 degrees Celsius] or lower must be maintained in the storage area of the vehicle.

2. All milk and milk products, except frozen desserts, must be maintained at forty-one degrees Fahrenheit [5 degrees Celsius] or lower. Ultrapasteurized and aseptically processed dairy products are exempt from this requirement.

3. Frozen desserts must be properly cooled to maintain solid form and texture.

4. The interior of the storage area must be cleaned daily and be free from insects and rodents.

5. An approved thermometer must be mounted in the storage area of all vehicles.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-39

**7-03.2-14-03. Outdated products.** Dairy products that have exceeded their code date for retail sale may not be transported from the processing plant if offered for sale.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-39

## CHAPTER 7-03.2-15
## BUTTERFAT TEST

Section
7-03.2-15-01 Butterfat Test Fee

**7-03.2-15-01. Butterfat test fee.** A fee of ten dollars for each party involved in the dispute must be charged for an official butterfat test.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-47

## CHAPTER 7-03.2-16
## LABELING MILK AND MILK PRODUCTS FOR RETAIL SALE AND OUT-OF-STATE BUTTER

Section

7-03.2-16-01 Federal Labeling Requirements
7-03.2-16-02 Cheese Labeling
7-03.2-16-03 Sodium Labeling
7-03.2-16-04 Frozen Desserts
7-03.2-16-05 Out-of-State Butter

**7-03.2-16-01. Federal labeling requirements.** All milk and milk products must comply with the labeling and nomenclature requirements of title 21, Code of Federal Regulations, parts 131, 133, and 135, and section 343(q)( r) of title 21, United States Code.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-35, 4-30-36, 4-30-45.1

**7-03.2-16-02. Cheese labeling.**

1. Bulk cheese must be legibly marked with:

   a. The name of the product.

   b. Date of manufacture.

   c. Vat number.

   d. The manufacturer's officially designated code number or name and address.

   e. A statement whether the product is pasteurized or heat-treated, or intended for further processing.

   f. Other information as required by United States department of agriculture regulations and by 21 United States Code 343(q)(r).

2. Each consumer-sized container must be marked with:

   a. Name and address of the manufacturer or United States department of agriculture code.

   b. Name of packer or distributor.

   c. Net weight of the contents.

d. Name of the product.

e. Date of manufacture.

f. Date of packing.

g. Other information as required by title 21, Code of Federal Regulations, part 133.

3. In lieu of the requirements of subsection 2 where it is not practical to label consumer-sized packages consistent with the requirements in subsection 2, a record of processing dates, product names, vat numbers, and plant code of the original bulk cheese must be kept on file at the particular establishment for one year and made available to the commissioner upon request.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-35, 4-30-36, 4-30-45.1

**7-03.2-16-03. Sodium labeling.** Sodium labeling must comply with 21 United States Code 343(q)(r).

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-35, 4-30-36, 4-30-45.1

**7-03.2-16-04. Frozen desserts.** All frozen dessert labels must include:

1. Name of product.

2. Name of plant that processed the product.

3. Address of processor.

4. Size or volume of container.

5. Whether the product is naturally or artificially flavored.

6. List of ingredients in descending order.

7. Other pertinent information as required by United States department of agriculture regulations and 21 United States Code 343(q)(r).

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-35, 4-30-36, 4-30-45.1

**7-03.2-16-05. Out-of-state butter.** All butter coming into North Dakota must be from United States department of agriculture-listed plants.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-35, 4-30-36

## CHAPTER 7-03.2-17
## GOAT AND SHEEP MILK PRODUCTION AND PROCESSING

Section
7-03.2-17-01 Requirements

**7-03.2-17-01. Requirements.**

1. All grade A goat and sheep milk must be produced according to the pasteurized milk ordinance.

2. Processing goat and sheep milk must meet the United States department of agriculture's manufacturing rules if the milk is to be sold as manufacturing grade milk, but if it is to be sold as grade A milk then it must meet the pasteurized milk ordinance.

3. All raw goat and sheep milk must be pasteurized or heat-treated before being used in cheese or other food products intended for human consumption. All cheeses must be properly identified as to type of the product and ingredients, and all heat-treated cheeses must be aged at least six months before being offered for human consumption.

4. The commissioner may modify the requirements of this section if the commissioner finds that the health, safety, and welfare of the general public, as well as the quality of the product, will not be compromised.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-27

## CHAPTER 7-03.2-18
## DISTRIBUTORS OF MILK AND MILK PRODUCTS

Section

7-03.2-18-01 Licensing Requirements
7-03.2-18-02 Origin of Grade A Products
7-03.2-18-03 Compliance With Federal Rules

**7-03.2-18-01. Licensing requirements.** Any person wanting to be a distributor of milk and milk products must be licensed by the commissioner. Before issuing a license, the commissioner must inspect the applicant's facilities and equipment.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-02, 4-30-39

**7-03.2-18-02. Origin of grade A products.** A distributor may distribute grade A milk and milk products provided that they are produced by a facility approved and listed as an interstate milk shipper by the interstate milk shippers association.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-02, 4-30-39

**7-03.2-18-03. Compliance with federal rules.** A distributor must comply with the pasteurized milk ordinance.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 4-30-55.1
**Law Implemented:** NDCC 4-30-02, 4-30-39

## CHAPTER 7-13-01

**7-13-01-03. Federal law.** All federal meat and poultry inspection regulations effective as of ~~August 1, 2003~~ January 1, 2009, as provided under title 9, Code of Federal Regulations, parts 301-320, 325, 329, 381, 391, 416-417, 424, 430, 441, and 500, but excluding parts 307.5 and 381.38, are incorporated by reference and made a part of this title.

**History:** Effective August 1, 2000; amended effective January 1, 2004; July 1, 2009.
**General Authority:** NDCC 36-24-24
**Law Implemented:** NDCC 36-24-18, 36-24-24

# TITLE 13

# DEPARTMENT OF FINANCIAL INSTITUTIONS

**JULY 2009**

## CHAPTER 13-02-15

**13-02-15-01. Definitions.**

1. "Bank funds" means cash or any check whereby the drawer and drawee are the lending bank, including a cashier's check.

2. "Core banking activity" includes receiving deposits, paying checks, or lending money.

3. "Loan production office" means an office ~~in North Dakota~~ which is apart from ~~a North Dakota state-chartered bank's~~ the main bank, ~~banking house or office, walk-in and drive-up~~ facility, or ~~paying and receiving station~~ interstate branch, where loans are solicited but ~~are not approved or disbursed~~ money is not lent.

4. "Money" is "lent" only when the borrower receives loan proceeds in person directly from bank funds either:

   a. At the lending bank or its operating subsidiary; or

   b. At a facility established by the lending bank or its operating subsidiary.

5. "Receipt of bank funds representing loan proceeds" does not include delivery of bank funds directly by a third party provided it does not occur at a place established by the bank or its operating subsidiary.

6. "Third party" is a person who customarily delivers loan proceeds directly from bank funds under accepted industry practice such as an attorney or escrow agent at a real estate closing.

**History:** Effective May 1, 1993; amended effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-15-02. Authorization of loan production offices.** The commissioner ~~or the board shall~~ may authorize the establishment of intrastate and interstate loan production offices by North Dakota state-chartered banks. In determining whether to approve the application for a loan production office, the commissioner shall take into consideration the following:

1. Whether the applicant bank is at least adequately capitalized per the most recently filed report of condition and income;

2. The volume of loans that applicant anticipates generating;

3. The information provided pursuant to section 13-02-15-04; and

4. Any other information the commissioner deems appropriate.

If an application for the establishment of a loan production office is denied by the commissioner, the applicant bank may appeal the decision of the commissioner to the state banking board.

**History:** Effective May 1, 1993; amended effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-15-03. Limitation.** Loan production offices may not be established when the establishment of such offices would impair the applicant bank's capital structure. There are no population or geographic restrictions applied to such offices in the state of North Dakota. This chapter does not ~~authorize~~ prohibit the establishment of a loan production office in North Dakota by ~~state-chartered~~ banks located in other states provided the other state allows a North Dakota state-chartered bank to establish a loan production office in the other state.

**History:** Effective May 1, 1993; amended effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-15-04. Permissible ~~activity~~ activities.** Loan production offices are limited to the following ~~activity~~ activities:

1. Soliciting loans on behalf of a bank~~, banking house or office, walk-in and drive-up facility, or paying and receiving station~~.

2. Assembling credit information.

3. Conducting property inspections and appraisals.

4. Securing title information.

5. Preparing applications for loans, including making ~~recommendations with respect to action~~ credit decisions provided money is not lent at the loan production office.

6. Any other activity which does not constitute a core banking activity as determined by the state banking board.

**History:** Effective May 1, 1993; amended effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-15-06. Revocation of certificate of authority.** The commissioner ~~shall~~ may revoke the certificate of authority for a loan production office where it has been determined a loan production office has engaged in any activity not specifically provided for in section 13-02-15-04.

**History:** Effective May 1, 1993; amended effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

## CHAPTER 13-02-22
## DEPOSIT PRODUCTION OFFICES

Section

13-02-22-01 Definitions
13-02-22-02 Authorization of Deposit Production Offices
13-02-22-03 Limitation
13-02-22-04 Permissible Activities
13-02-22-05 Deposit Production Office Application
13-02-22-06 Revocation of Certificate of Authority
13-02-22-07 Appeal

**13-02-22-01. Definitions.**

1. "Deposit production office" means an office which is apart from the bank's main office, facility, or interstate branch where deposits are solicited but are not received, nor are withdrawals paid or loans made.

2. "Impairment of capital" means the tier 1 leverage capital ratio in the bank's most recent quarterly report of condition and income is less than five percent.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-22-02. Authorization of deposit production offices.** The commissioner may authorize the establishment of deposit production offices by state-chartered banks. In determining whether to approve the application for a deposit office the commissioner shall take into consideration the following:

1. Whether the applicant bank is at least adequately capitalized per the most recently filed report of condition and income;

2. The volume of deposits that applicant anticipates generating;

3. The information provided pursuant to section 13-02-22-05; and

4. Any other information the commissioner deems appropriate.

If an application for the establishment of a deposit production office is denied by the commissioner, the applicant bank may appeal the decision of the commissioner to the state banking board.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-22-03. Limitation.** Deposit production offices may not be established when the establishment of such offices would impair the applicant bank's capital structure. There are no population or geographic restrictions applied to such offices in the state of North Dakota.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-22-04. Permissible activities.** Deposit production offices are limited to the following activities:

1. Soliciting deposits on behalf of a bank, facility, or interstate branch.

2. Providing information about deposit products.

3. Assisting persons in completing forms and related documents to open a deposit account and forwarding the forms and documents to the main bank, facility, or interstate branch.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-22-05. Deposit production office application.** A deposit production office may not be established or operated by a state-chartered bank until after the bank has submitted a written application to the commissioner or board and received a certificate of authority to operate such office. The application must describe with regard to the deposit production office the following:

1. The location.

2. A general description of the area where located, e.g., shopping center, supermarket, department store, etc.

3. The proposed activity for the location.

4. Whether the location will be staffed and, if so, the nature of employee compensation, whether an employee of the bank or a fee and commission basis.

5. Description as to the types of deposits to be solicited.

6. Any other information the commissioner determines necessary.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-22-06. Revocation of certificate of authority.** The commissioner may revoke the certificate of authority for a deposit production office where it has been determined a deposit production office has engaged in any activity not specifically provided for in section 13-02-22-04.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

**13-02-22-07. Appeal.** A bank whose certificate of authority has been revoked may appeal the commissioner's decision for consideration of the board if the appeal is filed within fifteen days after receipt of notice of certificate revocation. Consideration of the board must occur within sixty days after the date the appeal is filed.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 6-01-04, 6-03-02
**Law Implemented:** NDCC 6-03-38

# TITLE 28

# STATE BOARD OF REGISTRATION FOR PROFESSIONAL ENGINEERS AND LAND SURVEYORS

**JULY 2009**

**CHAPTER 28-02.1-13**

**28-02.1-13-01. Survey requirements for preparation of legal descriptions and conveyance of property.** Any registrant preparing a description, including without limitation a legal, property, or boundary description for, or assisting in the filing of, a document that will, or may, be used to convey real property or any interest therein, other than easements, including without limitation an auditor's plat, outlot, deed, or conveyance of ~~easements or right~~ rights of ~~ways~~ way, must conduct a survey of the property being conveyed and comply with all the requirements related thereto contained in North Dakota Century Code sections 40-50.1-01 and 40-50.1-02 ~~provided that descriptions used in the conveyance of right of ways or easements may be prepared if the right of ways or easements are temporary. In addition, descriptions~~.

Descriptions used in conveyances of ~~right~~ rights of ~~ways and easements~~ way in which possession of title is obtained may ~~also~~ be prepared without the setting of all exterior monuments if all four of the following requirements are met:

1. The ~~right~~ rights of ~~ways or easements~~ way are ~~traceable~~ retraceable by using established monuments;

2. Exterior monuments are set wherever there is a change of width to the ~~right~~ rights of ~~ways or easements~~ way;

3. Exterior monuments are set wherever there is a change in direction of the ~~right~~ rights of ~~ways or easements~~ way other than changes of direction at section corners; and

4. Monuments are set at intersections of ~~right~~ rights of ~~ways or easements~~ way with section lines or section line rights of way.

Descriptions used in the conveyance of easements having a term of five years or more must be retraceable in each section of land over which they cross by using

established subdivision or public land survey system monuments existing or placed at the time of the easement conveyance.

**History:** Effective October 1, 2004; amended effective July 1, 2009.
**General Authority:** NDCC 43-19.1-08
**Law Implemented:** NDCC 43-19.1-01, 43-19.1-08

# TITLE 33

# STATE DEPARTMENT OF HEALTH

## JULY 2009

## CHAPTER 33-07-01.1

**33-07-01.1-20. Medical records services.**

1. The general acute hospital shall establish and implement procedures to ensure that the hospital has a medical records service with administrative responsibility for medical records.

   a. A medical record must be maintained and kept confidential, in accordance with accepted medical record principles, for every patient admitted for care in the hospital.

      (1) Only authorized personnel may have access to the record.

      (2) Written consent of the patient must be presented as authority for release of medical information.

      (3) Medical records may not be removed from the hospital environment except upon subpoena or court order.

      (4) If a hospital discontinues operation, it shall make known to the department where its records are stored. Records are to be stored in a facility offering retrieval services for at least ten years after the closure date. Prior to destruction, public notice must be made to permit former patients or their representatives to claim their own records. Public notice must be in at least two forms, legal notice and display advertisement in a newspaper of general circulation.

   b. Records must be preserved in original or any other method of preservation, such as by microfilm, for a period of at least the tenth anniversary of the date on which the patient who is the subject of the record was last treated in the hospital.

      (1) If a patient was less than eighteen years of age at the time of last treatment, the hospital may authorize the disposal of

medical records relating to the patient on or after the date of the patient's twenty-first birthday or on or after the tenth anniversary of the date on which the patient was last treated, whichever is later.

(2) The hospital may not destroy medical records that relate to any matter that is involved in litigation if the hospital knows the litigation has not been finally resolved.

(3) It is the governing body's responsibility to determine which records have research, legal, or medical value and to preserve such records beyond the above-identified timeframes until such time in the governing body's determination the record no longer has a research, legal, or medical value.

c. If a registered record administrator or accredited record technician is not in charge of medical records, a consultant registered record administrator or accredited record technician shall organize the service, coordinate the training of the personnel, and make at least quarterly visits to the hospital to evaluate the records and the operation of the service.

d. Personnel must be available so that medical records services may be provided as needed.

e. A system of identification and filing to ensure the prompt location of a patient's medical record must be maintained.

f. Upon discharge, all clinical information pertaining to a patient's hospitalization must be centralized in the patient's medical record. The original of all reports must be filed in the medical record.

g. Records must be retrievable by disease, operation, and licensed health care practitioner and must be kept up to date. For abstracting, any recognized system may be used. Indexing must be current within six months following discharge of the patient.

h. The medical records must contain sufficient information to justify the diagnosis and warrant the treatment and end results. The medical records must contain the following information: identification data, chief complaint, present illness, past history, family history, physical examination, provisional diagnosis, treatment, progress notes, final diagnosis, discharge summary, nurses' notes, clinical laboratory reports, x-ray reports, consultation reports, surgical and tissue reports and applicable autopsy findings. Progress notes must be informative and descriptive of the care given and must include information and observations of significance so that they contribute to continuity of patient care.

(1) The chief complaint must include a concise statement of complaints that led the patient to consult the patient's licensed health care practitioner and the date of onset and duration of each.

(2) The physical examination statement must include all findings resulting from an inventory of systems.

(3) The provisional diagnosis must be an impression (diagnosis) reflecting the examining licensed health care practitioner's evaluation of the patient's condition based mainly on physical findings and history.

(4) Progress notes must give a chronological picture of the patient's progress and must be sufficient to delineate the course and results of treatment. The condition of the patient determines the frequency with which they are made.

(5) A definitive final diagnosis must be expressed in terminology of a recognized system of disease nomenclature.

(6) The discharge summary must be a recapitulation of the significant findings and events of the patient's hospitalization and the patient's condition on discharge.

(7) The consultation report must be a written opinion signed by the consultant including the consultant's findings.

(8) All diagnostic and treatment procedures must be recorded in the medical record.

(9) Tissue reports must include a report of microscopic findings if hospital regulations require that microscopic examination be done. If only gross examination is warranted, a statement that the tissue has been received and a gross description must be made by the laboratory and filed in the medical record.

(10) When an autopsy is performed, findings in a complete protocol must be filed in the record.

(11) Complete records, both medical and dental, of each dental patient must be a part of the hospital record.

i. All entries into the medical record must be authenticated by the individual who made the written entry.

(1) All entries that the licensed health care practitioner personally makes in writing must be signed and dated by that licensed health care practitioner.

(2) Telephone and verbal orders may be used provided they are given only to qualified licensed personnel and reduced to writing and dated, timed, and signed or initialed by a licensed health care practitioner responsible for the care of the patient within forty-eight hours unless the hospital policies and procedures for verbal orders and telephone orders include a process by which the reviewer of the order reads the order back to the ordering practitioner to verify its accuracy. For verbal orders and telephone orders using the read-back and verify process, the verbal orders and telephone orders must be authenticated within thirty days of discharge or within thirty days of the date the order was given if the length of stay is longer than thirty days.

(3) In hospitals with medical students and unlicensed residents, the attending licensed health care practitioner shall countersign at least the history and physical examination and summary written by the medical students and unlicensed residents.

(4) Signature stamps may be utilized consistent with hospital policies as long as the signature stamp is utilized only by the licensed health care practitioner whose signature the signature stamp represents. Written assurance must be on file from the licensed health care practitioner to indicate that the practitioner is the sole user of the signature stamp.

(5) Electronic signatures may be utilized if the hospital's medical staff and governing body adopt a policy that permits authentication by electronic signature. The policy must include:

(a) The categories of medical staff and other staff within the hospital who are authorized to authenticate patients' medical records using electronic signatures.

(b) The safeguards to ensure confidentiality, including:

[1] Each user must be assigned a unique identifier that is generated through a confidential access code.

[2] The hospital shall certify in writing that each identifier is kept strictly confidential. This certification must include a commitment to terminate the user's use of that particular identifier if it is found that the identifier has been misused. Misused means that the user has allowed another individual to use the user's personally assigned

identifier, or that the identifier has otherwise been inappropriately used.

[3] The user must certify in writing that the user is the only individual with user access to the identifier and the only individual authorized to use the signature code.

[4] The hospital shall monitor the use of the identifiers periodically and take corrective action as needed. The process by which the hospital will conduct the monitoring must be described in the policy.

(c) A process to verify the accuracy of the content of the authenticated entries, including:

[1] A system that requires completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps, or obvious contradictory statements appearing within those designated fields. The system must require that correction or supplementation of previously authenticated entries must be made by additional entries, separately authenticated and made subsequent in time to the original entry.

[2] The system must make an opportunity available to the user to verify that the document is accurate and that the signature has been properly recorded.

[3] As a part of the quality improvement activities, the hospital shall periodically sample records generated by the system to verify the accuracy and integrity of the system.

(d) A user may terminate authorization for use of an electronic signature upon written notice to the staff member in charge of medical records or other person designated by the hospital's policy.

(e) Each report generated by the user must be separately authenticated.

(f) A list of these codes must be maintained under adequate safeguards by hospital administration.

j. Current records and those on discharged patients must be completed promptly.

(1) Past history and physical examination information must be completed within twenty-four hours following admission.

(2) All reports or records must be completed and filed within a period consistent with current medical practice and not longer than thirty days following discharge.

(3) If a patient is readmitted within a month's time for the same conditions, reference to the previous history with an interval note and physical examination suffices.

2. Primary care hospitals are subject to the medical records services requirements for general acute hospitals in this section.

3. Specialized hospitals are subject to the medical records services requirements for general acute hospitals in this section.

**History:** Effective April 1, 1994; amended effective July 1, 2004; July 1, 2009.
**General Authority:** NDCC 23-01-03(3), 28-32-02
**Law Implemented:** NDCC 23-16-06, 31-08-01.2, 31-08-01.3

# TITLE 37

# DEPARTMENT OF TRANSPORTATION

## JULY 2009

## CHAPTER 37-10-01

**37-10-01-02. Penalty for violating out-of-service order.** A person convicted of violating an out-of-service order issued under section 37-10-01-01 is deemed to have committed the offense of driving under suspension under North Dakota Century Code section 39-06-42. The suspension periods for driving a commercial motor vehicle in violation of the out-of-service order are:

1. For a first violation, the driver must be suspended for a period of ~~ninety~~ one hundred eighty days;

2. For a second violation within ten years arising from separate incidents, the driver must be suspended for a period of ~~one year~~ two years; and

3. For a third or subsequent violation within ten years arising from separate incidents, the driver must be suspended for a period of three years.

If the violation occurred while transporting hazardous material required to be placarded or while operating a motor vehicle designed to transport sixteen or more passengers including the driver, the suspension period must be one hundred eighty days for a first violation and three years for each subsequent violation arising from a separate incident during a ten-year period.

**History:** Effective June 1, 1998; amended effective July 1, 2009.
**General Authority:** NDCC 39-06.2-14
**Law Implemented:** NDCC 39-06.2-10.9; 49 CFR 383.51

**37-10-01-05. Extension of commercial license suspension or revocation.** The director, who shall follow the administrative hearing procedures provided in North Dakota Century Code section 39-06.2-10, upon receiving a record of the conviction of any person upon a charge of driving a commercial motor vehicle while the commercial driver's license or commercial driving privileges of the person are suspended ~~or~~, revoked, or canceled shall extend the period of that suspension ~~or~~, revocation, or cancellation or otherwise disqualified for:

1. A period of one year if the operator's record shows the person's commercial driver's license or commercial driving privileges have not previously been suspended, revoked, canceled, or otherwise disqualified;

2. Lifetime if the operator's record shows the person's commercial driver's license or commercial driving privileges have previously been suspended, revoked, canceled, or otherwise disqualified for any of the major offenses under 49 CFR 383.51(b); or

3. A period of three years, if the driver is convicted of a first violation of driving while privileges are suspended, revoked, canceled, or otherwise disqualified while transporting hazardous materials required to be placarded, or while operating commercial motor vehicles designed to transport more than sixteen passengers, including the driver.

**History:** Effective January 1, 2006; amended effective July 1, 2009.
**General Authority:** NDCC 39-06.2-14
**Law Implemented:** NDCC 39-06.2-10.9; 49 CFR 383.51

**37-10-01-07. Civil penalty for driver conviction of out-of-service order.** Any driver who is convicted of violating an out-of-service order in which the driver, the vehicle, or the motor carrier operation has been placed out of service, is subject to a civil penalty of not less than ~~one~~ two thousand ~~one~~ five hundred dollars for a first conviction and not ~~more~~ less than ~~two~~ five thousand ~~seven hundred fifty~~ dollars for a second or subsequent conviction. Prior to a civil penalty being imposed, a driver has a right to an administrative hearing as provided for in North Dakota Century Code section 39-06.2-10.

**History:** Effective January 1, 2006; amended effective July 1, 2009.
**General Authority:** NDCC 39-06.2-10.9
**Law Implemented:** ~~NDCC~~ 49 CFR 383.53

**37-10-01-08. Civil penalty for employer conviction of out-of-service order.** Any employer who is convicted of knowingly allowing, requiring, permitting, or authorizing a driver to operate a commercial motor vehicle during any period in which the driver is subject to an out-of-service order, the commercial motor vehicle the driver is operating is subject to an out-of-service order, or the motor carrier operation is subject to an out-of-service order, is subject to a civil penalty of not less than two thousand seven hundred fifty dollars and not more than ~~eleven~~ twenty-five thousand dollars. Prior to a civil penalty being imposed, an employer has a right to an administrative hearing as provided for in North Dakota Century Code section 39-06.2-10.

**History:** Effective January 1, 2006; amended effective July 1, 2009.
**General Authority:** NDCC 39-06.2-14
**Law Implemented:** NDCC 39-06.2-10.9; 49 CFR 383.53

## CHAPTER 37-10-03
## HAZARDOUS MATERIALS ENDORSEMENT

Section
37-10-03-01 Transportation Security Administration Approval of Hazardous Materials Endorsement Issuances

**37-10-03-01. Transportation security administration approval of hazardous materials endorsement issuances.** The director may not issue, renew, upgrade, or transfer a hazardous materials endorsement for a commercial driver's license to any individual authorizing that individual to operate a commercial motor vehicle transporting a hazardous material in commerce unless the transportation security administration has determined that the individual does not pose a security risk warranting denial of the endorsement.

The director shall immediately revoke or deny an individual's hazardous materials endorsement if the transportation security administration serves the state with an initial determination of threat assessment and immediate revocation. The director shall, within fifteen days, revoke or deny the individual's hazardous materials endorsement if the transportation security administration serves the state with a final determination of threat assessment.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 39-06.2-14
**Law Implemented:** 49 CFR 383.141, 49 CFR 1572.13

# TITLE 45

# INSURANCE COMMISSIONER

**JULY 2009**

**CHAPTER 45-06-01.1**

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

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

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

3. "Applicant" means:

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

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

~~2.~~ 4. "Bankruptcy" means when a medicare advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

~~3.~~ 5. "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

~~4.~~ 6. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

~~5.~~ 7. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three days.

~~6.~~ 8. a. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(1) A group health plan;

(2) Health insurance coverage;

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

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

~~8.~~ 10. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

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

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

~~9.~~ 11. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

~~10.~~ 12. "Medicare" means the Health Insurance for the Aged Act, title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

~~11.~~ 13. "Medicare advantage plan" means a plan of coverage for health benefits under medicare part C as defined in ~~[refer to definition of medicare advantage plan in~~ 42 U.S.C. 1395w-28(b)(1)~~]~~, and includes:

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

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

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

~~12.~~ 14. "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act [42 U.S.C. 1395 et seq.] or an issued policy under the demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. "Medicare supplement policy" does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D, or any health care prepayment plan that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act.

~~13.~~ 15. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

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

~~14.~~ 17. "Secretary" means the secretary of the United States department of health and human services.

**History:** Effective January 1, 1992; amended effective August 27, 1998; December 1, 2001; September 1, 2005; July 1, 2009.
**General Authority:** NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
**Law Implemented:** NDCC 26.1-36.1

**45-06-01.1-04. Policy provisions.**

1. Except for permitted preexisting condition clauses as described in subdivision a of subsection 1 of section 45-06-01.1-05 ~~and~~, subdivision a of subsection 1 of section 45-06-01.1-06, and subdivision a of subsection 1 of section 45-06-01.1-06.1, no policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

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

3. No medicare supplement policy or certificate in force in the state may contain benefits which duplicate benefits provided by medicare.

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

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

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

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

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

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

**45-06-01.1-05. Minimum benefit standards for prestandardized medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992.** No policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

benefits. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

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

2. **Minimum benefit standards.**

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

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

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

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

e. Coverage under medicare part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under part B.

f. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the medicare part B deductible (one hundred dollars).

g. Effective January 1, 1990, coverage under medicare part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal

regulations or already paid for under part A, subject to the medicare deductible amount.

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

**45-06-01.1-06. Benefit standards for 1990 standardized medicare supplement benefit plan policies or certificates issued ~~or delivered~~ for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010.** The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards:

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

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

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

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

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

   e. Each medicare supplement policy must be guaranteed renewable:

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

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

(3) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5 ~~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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   d. Coverage under medicare parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations unless replaced in accordance with federal regulations.

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

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

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

   b. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the

one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

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

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

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

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

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

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

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

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

~~(2)~~ (b) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(2) Reimbursement must be for the actual charges up to one hundred percent of the medicare-approved amount for each service, as if medicare were to cover the service as identified in American medical association current procedural terminology codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by medicare.

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

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

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

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

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

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

(2) Coverage requirements and limitations.

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

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

(c) Coverage is limited to:

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

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

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

[4] Seven visits in any one week.

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

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

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

[8] At-home recovery visits received during the period the insured is receiving medicare-approved home care services or no more than eight weeks after the service date of the last medicare-approved home health care visit.

(3) Coverage is excluded for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**45-06-01.1-06.1. Benefit standards for 2010 standardized medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010.** The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of North Dakota Century Code chapter 26.1-36.1.

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

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

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

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

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

   e. Each medicare supplement policy shall be guaranteed renewable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Coverage under medicare parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, unless replaced in accordance with federal regulations;

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "~~J~~ L" listed in this section and conform to the definitions in section 45-06-01.1-02 and contained in North Dakota Century Code section 26.1-36.1-01. Each benefit must be structured in accordance with the format provided in subsections 2 and 3 or 4 of section 45-06-01.1-06 and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

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

5. Makeup of benefit plans:

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

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

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

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

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

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

g. Standardized medicare supplement benefit high deductible plan "F" includes only the following: one hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection 2 of section 45-06-01.1-06, plus

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

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

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

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

k. Standardized medicare supplement benefit plan "J" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, one

hundred percent of the medicare part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in subdivisions a, b, c, e, g, h, i, and j of subsection 3 of section 45-06-01.1-06, respectively. The outpatient prescription drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

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

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

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

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

7. New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise

available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

**History:** Effective January 1, 1992; amended effective July 1, 1994; August 27, 1998; September 1, 2005; July 1, 2009.
**General Authority:** NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
**Law Implemented:** NDCC 26.1-36.1-02

**45-06-01.1-07.1. Standard medicare supplement benefit plans for 2010 standardized medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010.** The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of North Dakota Century Code chapter 26.1-36.1.

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

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

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

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

shown. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

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

5. Makeup of 2010 standardized benefit plans:

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

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

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

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

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

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

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

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

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

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

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

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

(3) Part A hospitalization after one hundred fifty days. Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare part A eligible expenses for

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

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

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

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

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

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

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

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

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

(1) The benefits described in paragraphs 1, 2, 3, and 8 of subdivision h of subsection 5 of section 45-06-01.1-07.1;

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

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

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

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

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

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

6. New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of medicare

supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

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

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

1. **Guaranteed issue.**

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

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

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

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

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

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

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

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

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

c. (1) The individual is enrolled with:

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

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

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

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

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

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

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

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

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

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

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

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

f. The individual, upon first becoming eligible for benefits under part A of medicare at age sixty-five, enrolls in a medicare advantage plan under part C of medicare, or in a program of all-inclusive care for the elderly ~~program~~ provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve months after the effective date of enrollment.

g. The individual enrolls in a medicare part D plan during the initial enrollment period and, at the time of enrollment in part D, was

enrolled under a medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare part D along with the application for a policy described in subdivision d of subsection 5.

3. **Guaranteed issue time periods.**

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

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

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

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

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

f. In the case of an individual described in subsection 2 but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of

disenrollment and ends on the date that is sixty-three days after the effective date.

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

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

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

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

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

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

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

        (2) After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient

prescription drug benefit, a medicare supplement policy described in this paragraph is:

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

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

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

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

6. **Notification provisions.**

a. At the time of an event described in subsection 2 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this section, and of the obligations of the issuers of medicare supplement policies under subsection 1. Such notice shall be communicated contemporaneously with the notification of termination.

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

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

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

1. **General rules.**

a. Medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract issued. Such provision must be appropriately captioned and must appear on the first page of the policy, and must include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement policies, or if the increased benefits or coverage is required by law. When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy.

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

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

e. Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. (1) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for medicare

must provide to those applicants a guide to health insurance for people with medicare in the form developed jointly by the national association of insurance commissioners and the centers for medicare and medicaid services and in a type size no smaller than twelve-point type. Delivery of the guide must be made whether or not such policies or certificates are advertised, solicited, or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the guide must be made to the applicant at the time of application and acknowledgment of receipt of the guide must be obtained by the insurer. Direct response issuers must deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

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

2. **Notice requirements.**

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

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

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

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

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

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

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

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

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

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

   c. The outline of coverage provided to applicants pursuant to this section ~~must consist~~ consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed below in no less than twelve-point type. All plans ~~"A" through "L"~~ 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: 1 of 2

Benefit Plans ____________ [insert letters of plans being offered]

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

**See Outlines of Coverage sections for details about ALL plans**

**Basic Benefits for Plans A-J:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

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 Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | |
| | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | | Part 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 | |

| A | B | C | D | E | F | F* | G | H | I | J | J* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | At-Home Recovery | | | | At-Home Recovery | | At-Home Recovery | At-Home Recovery | |
| | | | | Preventive Care NOT covered by Medicare | | | | | | Preventive Care NOT covered by Medicare | |

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [$1,690] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [$1,690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page 2

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

| J | K*** | L** |
|---|---|---|
| Basic Benefits | 100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end<br>50% Hospice cost-sharing<br>50% of Medicare-eligible expenses for the first three pints of blood<br>50% Part B Coinsurance, except 100% Coinsurance for Part B preventive services | 100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End<br>75% Hospice cost-sharing<br>75% of Medicare-eligible expenses for the first three pints of blood<br>75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services |
| Skilled Nursing Coinsurance | 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance |
| Part A Deductible | 50% Part A Deductible | 75% Part A Deductible |
| Part B Deductible | | |
| Part B Excess (100%) | | |
| Foreign Travel Emergency | | |
| At-Home Recovery | | |
| Preventive Care NOT covered by Medicare | | |
| | [$4,000] Out-of-Pocket Annual Limit*** | [$2,000] Out-of-Pocket Annual Limit*** |

****Plans K and L provide for different cost-sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.**

*****The out-of-pocket annual limit will increase each year for inflation.**

~~See Outlines of Coverage for details and exceptions.~~

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

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

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

**Basic Benefits:**

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

| A | B | C | D | F | F* | G | K | L | M | N |
|---|---|---|---|---|---|---|---|---|---|---|
| Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | | Basic, including 100% Part B coinsurance | Hospitalization and preventive care paid at 100%; other basic benefits paid at 50% | Hospitalization and preventive care paid at 100%; other basic benefits paid at 75% | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER |
| | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | | Skilled Nursing Facility Coinsurance | 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | | Part A Deductible | 50% Part A Deductible | 75% Part A Deductible | 50% Part A Deductible | Part A Deductible |
| | | Part B Deductible | | Part B Deductible | | | | | | |
| | | | | Part B Excess (100%) | | Part B Excess (100%) | | | | |
| | | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | | Foreign Travel Emergency | | | Foreign Travel Emergency | Foreign Travel Emergency |
| *Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. | | | | | | | Out-of-pocket limit [$4,620]; paid at 100% after limit reached | Out-of-pocket limit [$2,310]; paid at 100% after limit reached | | |

**PREMIUM INFORMATION** [Boldface Type]

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

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

**READ YOUR POLICY VERY CAREFULLY** [Boldface Type]

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

**RIGHT TO RETURN POLICY** [Boldface Type]

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

**POLICY REPLACEMENT** [Boldface Type]

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

**NOTICE** [Boldface Type]

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

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

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

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

**COMPLETE ANSWERS ARE VERY IMPORTANT** [Boldface Type]

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

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

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to subsection 4 of Section ~~45-06-01.1-07~~ 45-06-01.1-07.1.]

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

## 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 ~~[$876]~~ [$1,068] | $0 | ~~[$876]~~ [$1,068] (Part A deductible) |
| 61st thru 90th day | All but ~~[$219]~~ [$267] a day | ~~[$219]~~ [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but ~~[$438]~~ [$534] a day | ~~[$438]~~ [$534] a day | $0 |
| –Once lifetime reserve days are used: | | | |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility | | | |
| Within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but ~~[$109.50]~~ [$133.50] a day | $0 | Up to ~~[$109.50]~~ [$133.50] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPICE CARE** | | | |
| ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited ~~coinsurance~~ copayment/coinsurance for outpatient drugs and inpatient respite care | ~~$0~~ Medicare copayment/coinsurance | ~~Balance~~ $0 |

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

## PLAN A

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

* Once you have been billed ~~[$100]~~ [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

## PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** | | | |
| MEDICARE-APPROVED SERVICES | | | |
| –Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| –Durable medical equipment | | | |
| First ~~[$100]~~ [$135] of Medicare-approved amounts* | $0 | $0 | ~~[$100]~~ [$135] (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 ~~[$876]~~ [$1,068] | ~~[$876]~~ [$1,068] (Part A deductible) | $0 |
| 61st thru 90th day | All but ~~[$219]~~ [$267] a day | ~~[$219]~~ [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but ~~[$438]~~ [$534] a day | ~~[$438]~~ [$534] a day | $0 |
| –Once lifetime reserve days are used: | | | |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but ~~[$109.50]~~ [$133.50] a day | $0 | Up to ~~[$109.50]~~ [$133.50] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited ~~coinsurance~~ copayment/ coinsurance for outpatient drugs and inpatient respite care | ~~$0~~ Medicare copayment/ coinsurance | ~~Balance~~ $0 |

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

# PLAN B

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

* Once you have been billed ~~[$100]~~ [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

## PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** | | | |
| MEDICARE-APPROVED SERVICES | | | |
| –Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| –Durable medical equipment | | | |
| First [~~$100~~] [$135] of Medicare-approved amounts* | $0 | $0 | [~~$100~~] [$135] (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 ~~[$876]~~ [$1,068] | ~~[$876]~~ [$1,068] (Part A deductible) | $0 |
| 61st thru 90th day | All but ~~[$219]~~ [$267] a day | ~~[$219]~~ [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but ~~[$438]~~ [$534] a day | ~~[$438]~~ [$534] a day | $0 |
| –Once lifetime reserve days are used: | | | |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but ~~[$109.50]~~ [$133.50] a day | Up to ~~[$109.50]~~ [$133.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited ~~coinsurance~~ copayment/ coinsurance for outpatient drugs and inpatient respite care | ~~$0~~ Medicare copayment/ coinsurance | ~~Balance~~ $0 |

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

## PLAN C

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

* Once you have been billed ~~[$100]~~ [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

## PARTS A & B

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

## OTHER BENEFITS - NOT COVERED BY MEDICARE

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

## PLAN D

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but ~~[$876]~~ [$1,068] | ~~[$876]~~ [$1,068] (Part A deductible) | $0 |
| 61st thru 90th day | All but ~~[$219]~~ [$267] a day | ~~[$219]~~ [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but ~~[$438]~~ [$534] a day | ~~[$438]~~ [$534] a day | $0 |
| –Once lifetime reserve days are used: | | | |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but ~~[$109.50]~~ [$133.50] a day | Up to ~~[$109.50]~~ [$133.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited ~~coinsurance~~ copayment/ coinsurance for outpatient drugs and inpatient respite care | ~~$0~~ Medicare copayment/ coinsurance | ~~Balance~~ $0 |

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

## PLAN D

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

* Once you have been billed ~~[$100]~~ [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES–** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, | | | |
| First ~~[$100]~~ [$135] of Medicare-approved amounts* | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges (Above Medicare-approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next ~~[$100]~~ [$135] of Medicare-approved amounts* | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES–**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]~~ [$135] of Medicare-approved amounts* | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| ~~AT-HOME RECOVERY SERVICES–NOT COVERED BY MEDICARE~~ | | | |
| ~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~ | | | |
| ~~–Benefit for each visit~~ | ~~$0~~ | ~~Actual charges to $40 a visit~~ | ~~Balance~~ |
| ~~–Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit)~~ | ~~$0~~ | ~~Up to the number of Medicare-approved visits, not to exceed 7 each week~~ | |
| ~~–Calendar year maximum~~ | ~~$0~~ | ~~$1,600~~ | |

## OTHER BENEFITS - NOT COVERED BY MEDICARE

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

## 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 [$876] | [$876] (Part A deductible) | $0 |
| 61st thru 90th day | All but [$219] a day | [$219] a day | $0 |
| 91st day and after: | | | |
| =While using 60 lifetime reserve days | All but [$438] a day | [$438] a day | $0 |
| =Once lifetime reserve days are used: | | | |
| =Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| =Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [$109.50] a day | Up to [$109.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

~~****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 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**—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**<br>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**<br>Some annual physical and preventive tests and services 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 benefits as Plan F after one has paid a calendar year ~~[$1,690]~~ [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~[$1,690]~~ [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY ~~[$1,690]~~ [$2,000] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO ~~[$1,690]~~ [$2,000] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but ~~[$876]~~ [$1,068] | ~~[$876]~~ [$1,068] (Part A deductible) | $0 |
| 61st thru 90th day | All but ~~[$219]~~ [$267] a day | ~~[$219]~~ [$267] a day | $0 |
| 91st day and after: | | | |
| While using 60 lifetime reserve days | All but ~~[$438]~~ [$534] a day | ~~[$438]~~ [$534] a day | $0 |
| Once lifetime reserve days are used: | | | |
| Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0*** |
| Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but ~~[$109.50]~~ [$133.50] a day | Up to ~~[$109.50]~~ [$133.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY ~~[$1,690]~~ [$2,000] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO ~~[$1,690]~~ [$2,000] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **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~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited ~~coinsurance~~ copayment/ coinsurance for outpatient drugs and inpatient respite care | ~~$0~~ Medicare copayment/ coinsurance | ~~Balance~~ $0 |

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

## PLAN F or HIGH DEDUCTIBLE PLAN F

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

* Once you have been billed ~~[$100]~~ [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**[** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year ~~[$1,690]~~ [$2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are ~~[$1,690]~~ [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY ~~[$1,690]~~ [$2,000] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO ~~[$1,690]~~ [$2,000] 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]~~ [$135] of Medicare-approved amounts* | $0 | ~~[$100]~~ [$135] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next ~~[$100]~~ [$135] of Medicare-approved amounts* | $0 | ~~[$100]~~ [$135] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES–**TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PLAN F or HIGH DEDUCTIBLE PLAN F

## PARTS A & B

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY ~~[$1,690]~~ [$2,000] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO ~~[$1,690]~~ [$2,000] 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]~~ [$135] of Medicare-approved amounts* | $0 | ~~[$100]~~ [$135] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

## OTHER BENEFITS - NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY ~~[$1,690]~~ [$2,000] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO ~~[$1,690]~~ [$2,000] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL–NOT COVERED BY MEDICARE** | | | |
| Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

## PLAN G

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but ~~[$876]~~ [$1,068] | ~~[$876]~~ [$1,068] (Part A deductible) | $0 |
| 61st thru 90th day | All but ~~[$219]~~ [$267] a day | ~~[$219]~~ [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but ~~[$438]~~ [$534] a day | ~~[$438]~~ [$534] a day | $0 |
| –Once lifetime reserve days are used: | | | |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but ~~[$109.50]~~ [$133.50] a day | Up to ~~[$109.50]~~ [$133.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited ~~coinsurance~~ copayment/ coinsurance for outpatient drugs and inpatient respite care | ~~$0~~ Medicare copayment/ coinsurance | ~~Balance~~ $0 |

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

## PLAN G

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

* Once you have been billed ~~[$100]~~ [$133.50] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| 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]~~ [$135] of Medicare-approved amounts* | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges (Above Medicare-approved amounts) | $0 | 80% | ~~20%~~ $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next ~~[$100]~~ [$135] of Medicare-approved amounts* | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**--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]~~ [$135] of Medicare-approved amounts* | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| ~~AT-HOME RECOVERY SERVICES–NOT COVERED BY MEDICARE~~ | | | |
| ~~Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan~~ | | | |
| ~~–Benefit for each visit~~ | ~~$0~~ | ~~Actual charges to $40 a visit~~ | ~~Balance~~ |
| ~~–Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit)~~ | ~~$0~~ | ~~Up to the number of Medicare-approved visits, not to exceed 7 each week~~ | |
| ~~–Calendar year maximum~~ | ~~$0~~ | ~~$1,600~~ | |

## OTHER BENEFITS - NOT COVERED BY MEDICARE

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

# 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 [$876] | [$876] (Part A deductible) | $0 |
| 61st thru 90th day | All but [$219] a day | [$219] a day | $0 |
| 91st day and after: | | | |
| =While using 60 lifetime reserve days | All but [$438] a day | [$438] a day | $0 |
| =Once lifetime reserve days are used: | | | |
| =Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| =Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [$109.50] a day | Up to [$109.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

~~** **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—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**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

## ~~PLAN I~~

## ~~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 [$876]~~ | ~~[$876] (Part A deductible)~~ | ~~$0~~ |
| ~~61st thru 90th day~~ | ~~All but [$219] a day~~ | ~~[$219] a day~~ | ~~$0~~ |
| ~~91st day and after:~~ | | | |
| ~~=While using 60 lifetime reserve days~~ | ~~All but [$438] a day~~ | ~~[$438] a day~~ | ~~$0~~ |
| ~~=Once lifetime reserve days are used:~~ | | | |
| ~~=Additional 365 days~~ | ~~$0~~ | ~~100% of Medicare-eligible expenses~~ | ~~$0**~~ |
| ~~=Beyond the additional 365 days~~ | ~~$0~~ | ~~$0~~ | ~~All costs~~ |
| ~~**SKILLED NURSING FACILITY CARE***~~ | | | |
| ~~You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital~~ | | | |
| ~~First 20 days~~ | ~~All approved amounts~~ | ~~$0~~ | ~~$0~~ |
| ~~21st thru 100th day~~ | ~~All but [$109.50] a day~~ | ~~Up to [$109.50] a day~~ | ~~$0~~ |
| ~~101st day and after~~ | ~~$0~~ | ~~$0~~ | ~~All costs~~ |
| ~~**BLOOD**~~ | | | |
| ~~First 3 pints~~ | ~~$0~~ | ~~3 pints~~ | ~~$0~~ |
| ~~Additional amounts~~ | ~~100%~~ | ~~$0~~ | ~~$0~~ |
| ~~**HOSPICE CARE**~~ | | | |
| ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ | ~~All but very limited coinsurance for outpatient drugs and inpatient respite care~~ | ~~$0~~ | ~~Balance~~ |

~~** **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—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**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

## PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

**[** This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [$1,690] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1,690]. 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 [$1,690] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO [$1,690] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [$876] | [$876] (Part A deductible) | $0 |
| 61st thru 90th day | All but [$219] a day | [$219] a day | $0 |
| 91st day and after: | | | |
| =While using 60 lifetime reserve days | All but [$438] a day | [$438] a day | $0 |
| =Once lifetime reserve days are used: | | | |
| =Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0*** |
| =Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [$109.50] a day | Up to [$109.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY [$1,690] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO [$1,690] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| 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 [$1,690] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1,690]. 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 [$1,690] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO [$1,690] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |
| **MEDICAL EXPENSES -** | | | |
| IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, | | | |
| First [$100] of Medicare-approved amounts* | $0 | [$100] (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges (Above Medicare-approved amounts) | $0 | 100% | $0 |
| **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**–TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

(continued)

## PLAN J or HIGH DEDUCTIBLE PLAN J

## PARTS A & B

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY [$1,690] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO [$1,690] 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 [$1,690] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO [$1,690] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL=NOT COVERED BY MEDICARE**<br>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**<br>Some annual physical and preventive tests and services 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 K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~[$4,000]~~ [$4,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but ~~[$876]~~ [$1,068] | ~~[$438]~~ [$534] (50% of Part A deductible) | ~~[$438]~~ [$534] (50% of Part A deductible) ◆ |
| 61st thru 90th day | All but ~~[$219]~~ [$267] a day | ~~[$219]~~ [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but ~~[$438]~~ [$534] a day | | |
| –Once lifetime reserve days are used: | | ~~[$438]~~ [$534] a day | $0 |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0*** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| 21st thru 100th day | All but ~~[$109.50]~~ [$133.50] a day | Up to ~~[$54.75]~~ [$66.75] a day | Up to ~~[$54.75]~~ [$166.75] a day◆ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%◆ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| ~~Available as long as your doctor certifies you are terminally ill and you elect to receive these services~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness. | ~~Generally, most Medicare-eligible expenses~~ All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | 50% of ~~coinsurance or copayments~~ copayment/coinsurance | 50% of ~~coinsurance or copayments~~ Medicare copayment/coinsurance◆ |

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

## PLAN K

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

**** Once you have been billed ~~[$100]~~ [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES–** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, | | | |
| First ~~[$100]~~ [$135] of Medicare-approved amounts**** | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible)**** ◆ |
| Preventive benefits for Medicare-covered services | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 10% | Generally 10% ◆ |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of ~~[$4,000]~~ [$4,620])* |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50% ◆ |
| Next ~~[$100]~~ [$135] of Medicare-approved amounts**** | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible)**** ◆ |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 10% | Generally 10% ◆ |
| **CLINICAL LABORATORY SERVICES–**TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~[$4,000]~~ [$4,620] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN K**

**PARTS A & B**

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

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

## PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of ~~[$2,000]~~ [$2,310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but ~~[$876]~~ [$1,068] | ~~[$657]~~ [$808.50] (75% of Part A deductible) | ~~[$219]~~ [$267] (25% of Part A deductible) ◆ |
| 61st thru 90th day | All but ~~[$219]~~ [$267] a day | ~~[$219]~~ [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but ~~[$438]~~ [$534] a day | ~~[$438]~~ [$534] a day | $0 |
| –Once lifetime reserve days are used: | | | |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0*** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| 21st thru 100th day | All but ~~[$109.50]~~ [$133.50] a day | Up to ~~[$82.13]~~ [$100.13] a day | Up to ~~[$27.37]~~ [$33.38] a day ◆ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25% ◆ |
| 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~~ You must meet Medicare's requirements, including a doctor's certification of terminal illness. | ~~Generally, most Medicare-eligible expenses~~ All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | 75% of ~~coinsurance or copayments~~ copayment/coinsurance | 25% of ~~coinsurance or copayments~~ copayment/coinsurance ◆ |

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

## PLAN L

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

**** Once you have been billed ~~[$100]~~ [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES–** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, | | | |
| First ~~[$100]~~ [$135] of Medicare-approved amounts**** | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible)**** ◆ |
| Preventive benefits for Medicare-covered services | Generally 75% or more of Medicare-approved amounts | Remainder of Medicare-approved amounts | All costs above Medicare-approved amounts |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | Generally 5% ◆ |
| **Part B Excess Charges** (Above Medicare-approved amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of ~~[$2,000]~~ [$2,310])* |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25% ◆ |
| Next ~~[$100]~~ [$135] of Medicare-approved amounts**** | $0 | $0 | ~~[$100]~~ [$135] (Part B deductible) ◆ |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 15% | Generally 5% ◆ |
| **CLINICAL LABORATORY SERVICES–**TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~[$2,000]~~ [$2,310] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

## PLAN L

## PARTS A & B

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

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

## PLAN M

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [$1,068] | [$534] (50% of Part A deductible) | [$534] (50% of Part A deductible) |
| 61st thru 90th day | All but [$267] a day | [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but [$534] a day | [$534] a day | $0 |
| –Once lifetime reserve days are used: | | | |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [$133.50] a day | Up to [$133.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |

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

## PLAN M

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

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

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

## PLAN M

### PARTS A & B

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

### OTHER BENEFITS - NOT COVERED BY MEDICARE

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

## PLAN N

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [$1,068] | [$1,068] (Part A deductible) | $0 |
| 61st thru 90th day | All but [$267] a day | [$267] a day | $0 |
| 91st day and after: | | | |
| –While using 60 lifetime reserve days | All but [$534] a day | [$534] a day | $0 |
| –Once lifetime reserve days are used: | | | |
| –Additional 365 days | $0 | 100% of Medicare-eligible expenses | $0** |
| –Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but [$133.50] a day | Up to [$133.50] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | 0% |

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

## PLAN N

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

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**–TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

# PLAN N

## PARTS A & B

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

## OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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

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

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

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

**History:** Effective January 1, 1992; amended effective August 1, 1992; July 1, 1994; April 1, 1996; July 1, 1998; August 27, 1998; December 1, 2001; September 1, 2005; July 1, 2009.
**General Authority:** NDCC 26.1-36.1-03, 26.1-36.1-05
**Law Implemented:** NDCC 26.1-36.1-05

**45-06-01.1-20.1. Prohibition against use of genetic information and requests for genetic testing.** This section applies to all policies with policy years beginning on or after May 21, 2009.

1. An issuer of a medicare supplement policy or certificate shall not:

   a. Deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to such individual; and

   b. Discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to such individual.

2. Nothing in subsection a shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

   a. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

   b. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

3. An issuer of a medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

4. Subsection 3 shall not be construed to preclude an issuer of a medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with subsection 1.

5. For purposes of carrying out subsection 4, an issuer of a medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

6. Notwithstanding subsection 3, an issuer of a medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

a. The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

b. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts.

c. No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

d. The issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

e. The issuer complies with such other conditions as the secretary may by regulation require for activities conducted under this subsection.

7. An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

8. An issuer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

9. If an issuer of a medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subsection 8 if such request, requirement, or purchase is not in violation of subsection 7.

10. For the purposes of this section only:

a. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

b. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

c. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

d. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

e. "Issuer of a medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

f. "Underwriting purposes" means:

(1) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(2) The computation of premium or contribution amounts under the policy;

(3) The application of any preexisting condition exclusion under the policy; and

(4) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

**History:** Effective July 1, 2009.
**General Authority:** NDCC 26.1-36.1-02(1)(20), 26.1-36.1-03
**Law Implemented:** NDCC 26.1-36.1-02