CHAPTER 26.1-36
ACCIDENT AND HEALTH INSURANCE

26.1-36-01. Scope.

No section of this chapter applies to or affects any policy of workforce safety and insurance or any policy of liability insurance with or without supplementary expense coverage therein; or any policy or contract of reinsurance; or any blanket or group insurance policy, except when the section refers to a blanket or group insurance policy; or life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as provide additional benefits in case of death or dismemberment or loss of sight by accident, or as operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

26.1-36-01.1. Scope - Accident and health insurance policy mandates.

Unless expressly provided otherwise, an accident and health insurance policy health coverage mandate under this chapter does not apply to an accident and health insurance policy that is a high-deductible health plan under 26 U.S.C. 223 if the mandate would cause the policy to fail to qualify as a high-deductible health plan under this federal law.

26.1-36-01.2. Examinations.

1. As used in this section, the terms "health carrier" and "health benefit plan" have the same meaning as provided under section 26.1-36.3-01.
2. Whenever the commissioner, in the commissioner's sole discretion, deems it appropriate, but at least once every five years, the commissioner or any of the commissioner's examiners shall conduct a comprehensive examination of a health carrier with a market share of twenty-five percent or more of health benefit plan covered lives in this state. The examination must be conducted in accordance with an examination conducted under chapter 26.1-03. In determining the scope of the comprehensive examination, the commissioner shall consider the criteria set forth in the market conduct handbook adopted by the national association of insurance commissioners and adopted by the commissioner which is in effect when the examination is initiated and any other matters deemed appropriate by the commissioner.

26.1-36-02. Accident and health insurance policy defined.

"Accident and health insurance policy" includes any contract policy insuring against loss resulting from sickness or bodily injury, or death by accident, or both.

26.1-36-02.1. Accident and health policies and certificates - Notice of free examination.

Accident and health policies and certificates must have a notice prominently printed on or attached to the first page of the policy or certificate stating in substance that the applicant may return the policy or certificate within ten days of its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

26.1-36-02.2. Individual health plans - Open enrollment periods - Rules.

1. As used in this section:
   a. "Adverse selection" occurs when an individual who experiences greater than average health risks seeks to purchase an individual health plan.
   b. "Annual open enrollment period" means a period each year during which an individual may enroll or change coverage in an individual health plan that is not sold through a health benefit exchange.

c. "Health benefit exchange" means a governmental agency or nonprofit entity that:
   (1) Meets the applicable requirements of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148] and the provisions of the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]; and
   (2) Makes qualified health plans available to qualified individuals and qualified employers through a state health benefit exchange, regional health benefit exchange, subsidiary health benefit exchange, or a federally facilitated health benefit exchange.

d. "Individual health plan" means health insurance coverage offered to individuals, other than in connection with a group health plan. The term does not include limited scope dental or vision benefits, coverage only for specified disease or illness, hospital indemnity or other fixed indemnity insurance, or other similar limited benefit health plans.

e. "Initial enrollment period" means a period during which an individual may enroll in individual health plan coverage sold outside a health benefit exchange for coverage during the 2014 benefit year.

f. "Special enrollment period" means a period that is outside of the initial and annual open enrollment periods, during which an individual or enrollee who experiences certain qualifying events may enroll in or change enrollment in an individual health plan not sold through a health benefit exchange.

2. The commissioner may adopt rules reasonably necessary to mitigate adverse selection or other undesirable market effect among individual health plans sold inside and among individual health plans sold outside a health benefit exchange. The rules may contain:
   a. Requirements for the initial enrollment period;
   b. Requirements for an annual open enrollment period;
   c. Requirements for a special enrollment period;
   d. Requirements for an individual who purchases individual health plan coverage during a special enrollment period; and
   e. Any other provision reasonably required to mitigate adverse selection or other undesirable market effect in individual health plans sold inside or outside a health benefit exchange.

26.1-36-03. Form of policy.

1. No accident and health insurance policy may be delivered or issued for delivery to any person in this state unless:
   a. The entire money and other considerations for the policy are expressed in the policy.
   b. The time at which the insurance takes effect and terminates is expressed in the policy.
   c. The policy purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is deemed the policyholder, any two or more eligible members of that family, including spouse, dependent children or any children under a specified age which may not exceed twenty-two years, and any other person dependent upon the policyholder.
   d. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which is uniform and not less than ten point with a lowercase unspaced alphabet length not less than one hundred twenty point. The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.
   e. The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 26.1-36-04, are printed at the insurer's option,

either included with the benefit provisions to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS". If an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

f. Each form, including riders and endorsements, must be identified by a form number in the lower left-hand corner of the first page thereof.

g. It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

2. If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the insurance department of that state has advised the commissioner that the policy is not subject to approval or disapproval by that official, the commissioner may by ruling require that the policy meet the standards set forth in subsection 1 and in section 26.1-36-04.

26.1-36-03.1. Information disclosure.

An insurance company, as defined in section 26.1-02-01, a health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless that insurer makes available to persons covered under the policy or contract a plan description that discloses in writing the terms and conditions of the policy or contract. The plan description must use the plain and ordinary meaning of words so as to reasonably ensure comprehension by a layperson and must be made available to each person covered under the contract, in any manner reasonably assuring availability prior to the delivery, issuance, execution, or renewal of the policy or contract.

1. The information required to be disclosed by the insurer must include, in addition to any other disclosures required by law:

   a. A general description of benefits and covered services, including benefit limits and coverage exclusions and the definition of medical necessity used by the insurer in determining whether benefits will be covered;

   b. A general description of the insured's financial responsibility for payment of premiums, deductibles, coinsurance, and copayment amounts, including any maximum limitations on out-of-pocket expenses, any maximum limits on payments for health care services, and the maximum out-of-pocket costs for services that are provided by nonparticipating health care professionals;

   c. A general explanation of the extent to which benefits and services may be obtained from nonparticipating providers, including any out-of-network coverage or options;

   d. A general explanation of the extent to which a person covered under the policy or contract may select from among participating providers and any limitations imposed on the selection of participating health care providers;

   e. A general description of the insurer's use of any prescription drug formulary or any other general limits on the availability of prescription drugs;

   f. A general description of the procedures and any conditions for persons covered under the policy or contract to change participating primary and specialty providers;

   g. A general description of the procedures and any conditions for obtaining referrals;

   h. A general description of the procedure for providing emergency services, including an explanation of what constitutes an emergency situation and notice that emergency services are not subject to prior authorization, the procedure for obtaining emergency services and any cost-sharing applicable to emergency services, including out-of-network services, and any limitation on access to emergency services;

i. A general description of any utilization review policies and procedures, including a description of any required prior authorizations or other requirements for health care services and appeal procedures;
j. A general description of all complaint or grievance rights and procedures used to resolve disputes between the insurer and persons covered under the policy or contract or a health care provider, including the method for filing grievances and the timeframes and circumstances for acting on grievances and appeals;
k. A general description of any methods used by the insurer for providing financial payment incentives or other payment arrangements to reimburse health care providers;
l. Notice of appropriate mailing addresses and telephone numbers to be used by persons covered under the policy or contract in seeking information or authorization for treatment;
m. If applicable, notice of the provisions required by section 26.1-47-03 that ensure access to health care services in preferred provider arrangements; and
n. Notice that the information described in subsection 2 is available upon request.

2. An insurer shall provide the following written information if requested by a person covered under a policy or contract:
   a. A description of any process for credentialing participating health care providers;
   b. A description of the policies and procedures established to ensure confidentiality of patient information;
   c. A description of the procedures followed by the insurer to make decisions about the experimental nature of individual drugs, medical devices, or treatments;
   d. With regard to any preferred provider arrangement or other network health plan, a list by specialty of the name and location of participating health care providers and the number, types, and geographic distribution of providers participating in the health plan; and
   e. Whether a specifically identified drug is included or excluded from coverage.
3. Nothing in this section may be construed as preventing an insurer from making the information under subsections 1 and 2 available to a person covered under the policy or contract through a handbook or similar publication.

26.1-36-04. Accident and health policy provisions.

1. Except as provided in subsection 3, each accident and health insurance policy delivered or issued for delivery to any person in this state must contain provisions described in this section. The provisions contained in any policy may not be less favorable in any respect to the insured or the beneficiary.
   a. A provision that the policy, including the endorsements and the attached papers, if any, constitutes the entire insurance contract and that no change in the policy is valid until approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the policy.
   b. A provision that no insurance producer has authority to change the policy or to waive any of its provisions.
   c. A provision that the validity of the policy may not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that the validity of the policy may not be contested on the basis of a statement made relating to insurability by any person covered under the policy after the insurance has been in force for two years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement; provided, however, that no such provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy.
   d. A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date

of the person's coverage under the policy. Any such exclusion or limitation may only apply to a pre-existing disease or physical condition for which medical advice or treatment was received by the person during the two-year period before the effective date of the person's coverage. The exclusion or limitation may not apply to loss incurred or disability commencing after the end of the two-year period commencing on the effective date of the person's coverage.

e. A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which the policy continues in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

f. A provision that if any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without requiring in connection therewith an application for reinstatement, reinstates the policy; provided, however, that if the insurer or the agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of the application by the insurer or, lacking the approval, upon the forty-fifth day following the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. The policy must provide that the reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to any sickness that begins more than ten days after the date. The policy must provide that in all other respects the insured and insurer have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed thereon or attached thereto in connection with the reinstatement. The provision may include a statement that any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement. This statement may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or in the case of a policy issued after age forty-four, for at least five years from its date of issue.

g. A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within this time does not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

h. A provision that the insurer will furnish to the person making claim, or to the policyholder for delivery to such person, the forms usually furnished for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making the claim is deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claims are made.

i. A provision that in the case of claim for loss of time for disability, written proof of loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proof of continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of loss must be furnished to the insurer within ninety days after the date of loss. Failure to furnish the proof within this time does not invalidate

nor reduce any claim if it was not reasonably possible to furnish the proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

j. A provision that all benefits payable under the policy other than benefits for loss of time will be payable according to the provisions of section 26.1-36-37.1, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of proof of loss.

k. A provision that benefits for loss of life of the person insured will be payable to the beneficiary designated by the insured person. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the insured person. All other benefits of the policy are payable to the insured person. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding five thousand dollars, to any relative by blood or connection by marriage of the person deemed by the insurer to be equitably entitled to the benefit.

l. A provision that the insurer may examine the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also may make an autopsy in case of death if the autopsy is not prohibited by law.

m. A provision that no action may be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action may be brought at all unless brought within three years from the expiration of the time which proof of loss is required by the policy.

n. A provision that in the event of the death of an insured, the insurer will refund within thirty days after notice to the insurer of the insured's death the portion of the premium, fees, or other sum paid beyond the month of death after deducting any claim for losses during the current term of the policy. This provision does not apply if the insurer has a valid defense to the payment of benefits under the policy.

2. Except as provided in subsection 3, an accident and health insurance policy delivered or issued for delivery to any person in this state may not contain provisions respecting the matters described in this subsection unless the provisions in the policy are not less favorable in any respect to the insured or the beneficiary.

a. A provision that if the insured is injured or contracts sickness after having changed occupation to one classified by the insurer as more hazardous than that stated in the policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in the policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes occupation to one classified by the insurer as less hazardous than that stated in the policy, the insurer, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of proof, whichever is the more recent. The provision must provide that the classification of occupational risk and the premium rates will be such as have been last filed by the insurer before the occurrence of the loss for which the insurer is liable or before date of

proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time the policy was issued; but if the filing was not required, then the classification of occupational risk and the premium rates will be those last made effective by the insurer in such state before the occurrence of the loss or before the date of proof of change in occupation.

b. A provision that if the age of the insured has been misstated, all amounts payable under the policy will be such as the premium paid would have purchased at the correct age.

c. A provision that if an accident or health or accident and health policy or policies previously issued by the insurer to the insured are in force concurrently therewith, making the aggregate indemnity for the type of coverage or coverages, in excess of the maximum limit of indemnity or indemnities, the excess insurance is void and all premiums paid for the excess will be returned to the insured or to the insured's estate. In lieu of this type of provision, the policy may provide that insurance effective at any one time on the insured under the policy and a like policy or policies in the insurer is limited to the one such policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

d. A provision that upon the payment of a claim under the policy, any premium then due and unpaid or covered by any note or written order may be deducted from the payment.

e. Subject to chapter 26.1-36.4, a provision that the insurer may cancel the policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer, stating when, not less than five days thereafter, the cancellation is effective; and after the policy has been continued beyond its original term the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in the notice. The provision must provide that in the event of cancellation, the insurer will return promptly the unearned portion of any premium paid, and, if the insured cancels, the earned premium will be computed by the use of the short-rate table last filed in the state where the insured resided when the policy was issued. The provision must provide that if the insurer cancels, the earned premium shall be computed pro rata. The provision must provide that cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

f. A provision that any provision of the policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is amended to conform to the minimum requirements of such statutes.

g. A provision that the insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

h. A provision that after the loss-of-time benefit of the policy has been payable for ninety days, such benefit will be adjusted, as provided under this subdivision, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured should exceed a percentage of the insured's earned income as provided in the policy; provided, however, that if the information contained in the application discloses that the total amount of loss-of-time benefits under the policy and under all other valid loss-of-time coverage expected to be effective upon the insured in accordance with the application for this policy exceeded an alternative percentage of the insured's earned income as provided in the policy, at the time of the application, such higher percentage will be used in place of the original percentage provided.

   (1) The provision must provide that the adjusted loss-of-time benefit under the policy for any month will be only such proportion of the loss-of-time benefit otherwise payable under the policy as (a) the product of the insured's

earned income and the original percent, or, if higher, the alternative percentage, bears to (b) the total amount of loss-of-time benefits payable for such month under the policy and all other valid loss-of-time coverage on the insured, without giving effect to the "overinsurance provision" in this or any other coverage, less in both (a) and (b) any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an "overinsurance provision".

(2) The provision must provide that in making the computation, all benefits and earnings will be converted to a consistent basis weekly if the loss-of-time benefit of the policy is payable weekly, or monthly if the benefit is payable monthly, or otherwise, based upon the time period. If the numerator of the foregoing ratio is zero or is negative, no benefit is payable.

(3) The provision must provide that in no event does the provision operate to reduce the total combined amount of loss-of-time benefits for such month payable under the policy and all other valid loss-of-time coverage below the lesser of three hundred dollars and the total combined amount of loss-of-time benefits determined without giving effect to any "overinsurance provision", nor operate to increase the amount of benefits payable under the policy above the amount which would have been paid in the absence of the provision, nor take into account or operate to reduce any benefit other than the loss-of-time benefit.

(4) The provision must provide that:

(a) "Earned income", except when otherwise specified, means the greater of the monthly earnings of the insured at the time disability commences and the insured's average monthly earnings for a period of two years immediately preceding the commencement of the disability, and does not include any investment income or any other income not derived from the insured's vocational activities.

(b) "Overinsurance provision" includes this type of provision and any other provision with respect to any loss-of-time coverage which may have the effect of reducing an insurer's liability if the total amount of loss-of-time benefits under all coverage exceeds a stated relationship to the insured's earnings.

(5) This type of provision may be included only in a policy that provides a loss-of-time benefit which may be payable for at least fifty-two weeks, which is issued on the basis of selective underwriting of each individual application, and for which the application includes a question designed to elicit information necessary either to determine the ratio of the total loss-of-time benefits of the insured to the insured's earned income or to determine that such ratio does not exceed the percentage of earnings, not less than sixty percent, selected by the insurer and inserted in lieu of the blank factor above. The insurer may require, as part of the proof of claim, the information necessary to administer this provision. If the application indicates that other loss-of-time coverage is to be discontinued, the amount of such other coverage must be excluded in computing the alternative percentage in the first sentence of the overinsurance provision. The policy must include a definition of "valid loss-of-time coverage" which may include coverage provided by governmental agencies and by organizations subject to regulation by insurance law and by insurance departments of this or any other state or of any other country or subdivision thereof, coverage provided for the insured pursuant to any disability benefits statute or any workforce safety and insurance or employer's liability statute, benefits provided by labor-management trusteed plans or union welfare plans or by employer or employee benefit organizations, or by salary continuance or pension programs, and any other coverage the inclusion of which may be approved.

3. If any requirement of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.
4. The provisions that are subject to subsections 1 and 2 must be printed in the consecutive order of the requirements in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy is not in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.
5. A provision not subject to this section may not make a policy, or any portion of the policy, less favorable in any respect to the insured or to the beneficiary than any provision which is subject to this chapter.
6. Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision that is not less favorable to the insured or the beneficiary than the provisions of this chapter and that is prescribed or required by the law of the state under which the insurer is organized. Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

26.1-36-05. Group health policy or service contract standard provisions.

Neither a group health insurance policy nor a group health service contract may be delivered in this state unless it contains in substance the following provisions, or provisions that in the opinion of the commissioner are more favorable to the persons insured and more favorable to the policyholder or contractholder; provided, however, that subsections 5, 7, and 12 do not apply to credit accident and health insurance policies, that the standard provisions required for individual health insurance policies do not apply to group health insurance policies, and that if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy or contract, the insurer shall omit from the policy or contract any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision to make the provision contained in the policy or contract consistent with the coverage provided by the policy or contract:

1. A provision that the policyholder or contractholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which the policy or contract continues in force, unless the policyholder or contractholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy or contract. The policy or contract may provide that the policyholder or contractholder is liable to the insurer for the payment of a pro rata premium for the time the policy or contract was in force during the grace period.
2. A provision that the validity of the policy or contract may not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that the validity of the policy or contract may not be contested on the basis of a statement made relating to insurability by any person covered under the policy or contract after the insurance has been in force for two years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement; provided, however, that no such provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or contract.
3. A provision that a copy of the application, if any, of the policyholder or contractholder will be attached to the policy or contract when issued, that all statements made by the policyholder or contractholder or by the persons insured are deemed representations and not warranties, and that no statement made by any insured person may be used in any contest unless a copy of the instrument containing the statement is or has been

furnished to that person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

4. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.
5. A provision specifying the additional exclusions or limitations, if any, applicable under the policy or contract with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy or contract. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months before the effective date of the person's coverage. The exclusion or limitation may not apply to loss incurred or disability commencing after the earlier of the end of a continuance period of twelve months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition, or the end of the two-year period commencing on the effective date of the person's coverage.
6. If the premiums or benefits vary by age, a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated. The provision must contain a clear statement of the method of adjustment to be used.
7. A provision that the insurer will issue to the policyholder or contractholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage.
8. A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy or contract. Failure to give notice within this time does not invalidate nor reduce any claim if it is shown that it was not reasonably possible to give the notice and that notice was given as soon as was reasonably possible.
9. A provision that the insurer will furnish to the person making claim, or to the policyholder or contractholder for delivery to the person making claim, the forms usually furnished for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy or contract, the person making the claim is deemed to have complied with the requirements of the policy or contract as to proof of loss upon submitting within the time fixed in the policy or contract for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.
10. A provision that in the case of claim for loss of time for disability, written proof of loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proof of continuance of the disability must be furnished to the insurer at intervals the insurer may reasonably require, and that in the case of claim for any other loss, written proof of loss must be furnished to the insurer within ninety days after the date of loss. Failure to furnish the proof within this time does not invalidate nor reduce any claim if it was not reasonably possible to furnish the proof within that time, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.
11. A provision that all benefits payable under the policy or contract other than benefits for loss of time or unless subject to section 26.1-36-37.1 will be payable not more than sixty days after receipt of due proof of loss. All accrued benefits payable under the policy or contract for loss of time will be paid at least monthly during the continuance of

the period for which the insurer is liable, and that any balance remaining unpaid at the termination of that period will be paid as soon as possible after receipt of proof of loss.

12. A provision that benefits for loss of life of the person insured will be payable to the beneficiary designated by the insured person. If the policy or contract contains conditions pertaining to family status, however, the beneficiary may be the family member specified by the policy or contract terms. In either case, payment of these benefits is subject to the provisions of the policy or contract in the event the designated or specified beneficiary is not living at the death of the insured person. All other benefits of the policy or contract are payable to the insured person. The policy or contract may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not exceeding five thousand dollars, to any relative by blood or connection by marriage of the person deemed by the insurer to be equitably entitled to the benefit.
13. A provision that the insurer may examine the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy or contract and also may make an autopsy in case of death when the autopsy is not prohibited by law.
14. A provision that no action may be brought to recover on the policy or contract prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy or contract and that the action may not be brought at all unless brought within three years from the expiration of the time which proof of loss is required by the policy or contract.
15. A provision that except as otherwise provided under this subsection, the insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a crime or to which a contributing cause was the insured's engagement in an illegal occupation. However, under this subsection the insurer is liable for a loss to the extent the crime committed was a misdemeanor violation of section 39-08-01.

26.1-36-06. Group health policy and medical service contract options for drugs and chiropractic care.

No insurance company or health service corporation may deliver, issue, execute, or renew any health insurance policy or medical service contract that includes coverage of medical benefits on a group, blanket, franchise, or association basis unless the insurer makes available, at the option of the policyholder, the following coverages for which an additional premium may be charged:

1. All drugs and medicines prescribed by the provider of health services.
2. Services rendered and care administered by chiropractors licensed under chapter 43-06.

26.1-36-06.1. Coverage for off-label uses of drugs.

1. In this section:
   a. "Coverage of a drug" includes medically necessary services associated with the administration of the drug.
   b. "Medical literature" means scientific studies published in a peer review national medical journal.
   c. "Off-label use of drugs" means prescribing drugs for treatments other than those stated in the labeling approved by the federal food and drug administration.
   d. "Standard reference compendia" means the United States pharmacopeia drug information or American hospital formulary service drug information.
2. An insurance company, nonprofit health service corporation, or health maintenance organization that provides coverage for drugs may not issue, deliver, execute, or renew any health insurance policy or health service contract on an individual, group, blanket, franchise, or association basis which excludes coverage of a drug for a particular indication on the grounds the drug has not been approved by the federal

food and drug administration for that indication if the drug is recognized for treatment of the indication in one of the standard reference compendia or medical literature.

3. The insurance commissioner may direct an insurer or contractor regulated by this section to make payments as required by this section.
4. The state health officer may appoint a panel of up to eight qualified medical experts to review off-label uses of drugs not included in the standard reference compendia or medical literature. This panel shall advise the insurance commissioner whether a particular off-label use is medically appropriate and shall make recommendations regarding payment of off-label use.
5. This section does not alter existing law regarding provisions limiting the coverage of drugs that have not been approved by the federal food and drug administration; does not require coverage for any drug when the federal food and drug administration has determined its use to be contraindicated; and does not require coverage for experimental drugs not otherwise approved for any indication by the federal food and drug administration.

26.1-36-07. Health insurance coverage for newborn and adopted children - Scope of coverage - Notification of birth or adoption.

1. All individual and group health insurance policies providing coverage on an expense-incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber must, as to the family members' coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber from the moment of birth and are also payable from the date of physical placement by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 with respect to an adopted child.
2. The coverage for newly born children and for children placed for adoption by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
3. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or child placed for adoption by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth or date of physical placement by a licensed child placement agency or by the birth parent pursuant to chapter 14-15.1 of the child in order to have the coverage continue beyond the thirty-one-day period.

26.1-36-08. Group health policy and health service contract substance abuse coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group, blanket, franchise, or association basis unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any individual covered under the policy or contract, for the diagnosis, evaluation, and treatment of alcoholism, drug addiction, or other related illness, which benefits meet or exceed the benefits provided in subsection 2.
2. The benefits must be provided for inpatient treatment, treatment by partial hospitalization, and outpatient treatment:
   a. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of sixty days of services covered under this section and section 26.1-36-09 in any calendar year. Services provided under this subdivision must be provided by an addiction treatment program licensed under chapter 50-31.

b. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section and section 26.1-36-09 in any calendar year. Services provided under this subdivision must be provided by an addiction treatment program licensed under chapter 50-31. For services provided in state-operated behavioral health clinics, charges must be reasonably similar to the charges for care provided by hospitals as defined in this subsection.

c. Benefits may also be provided for a combination of inpatient and partial hospitalization treatment. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by partial hospitalization, provided that no more than forty-six days of the inpatient treatment benefits required by this section may be traded for treatment by partial hospitalization.

d. In the case of benefits provided for outpatient treatment, the benefits must be provided for a minimum of twenty visits for services covered under this section in any calendar year, provided the diagnosis, evaluation, and treatment services are provided within the scope of licensure by a licensed physician, a licensed psychologist who is eligible for listing on the national register of health service providers in psychology, or the treatment services are provided within the scope of licensure by a licensed addiction counselor. The insurance company, nonprofit health service corporation, or health maintenance organization may not establish a deductible or a copayment for the first five visits in any calendar year, and may not establish a copayment greater than twenty percent for the remaining visits. The deductible limitation of this subdivision does not apply to a high-deductible health plan used to establish a health savings account pursuant to and as defined in section 223 of the Internal Revenue Code [26 U.S.C. 223].

e. If the services are provided by a provider outside a preferred provider network without a referral from within the network, the insurance company, nonprofit health service corporation, or health maintenance organization may establish a copayment greater than twenty percent for only those visits after the first five visits in any calendar year.

f. As used in this section and section 26.1-36-08.1, partial hospitalization means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

3. This section does not prevent any insurance company, nonprofit health service corporation, or health maintenance organization from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, when the policy or contract is not subject to such provisions.

26.1-36-08.1. Alternative group health policy and health service contract substance abuse coverage.

1. As an alternative to the substance abuse coverage required under subsection 2 of section 26.1-36-08, an insurance company, a nonprofit health service corporation, or a health maintenance organization may provide substance abuse coverage under this section.
2. The provisions of section 26.1-36-08 apply to this alternative, except:
   a. In addition to the inpatient treatment, treatment by partial hospitalization, and outpatient treatment coverage required under section 26.1-36-08, the coverage must include residential treatment.
   b. In the case of coverage for inpatient treatment, the benefits must be provided for a minimum of forty-five days of services covered under this section and section 26.1-36-09 in any calendar year.
   c. For the purpose of computing the period for which benefits are payable for a combination of inpatient and partial hospitalization, no more than twenty-three

days of inpatient treatment benefits required under subdivision a may be traded for treatment by partial hospitalization.

d. In the case of coverage for residential treatment, the benefits must be provided for a minimum of sixty days of services covered under this section in any calendar year. This residential treatment must be provided by an addiction treatment program licensed under chapter 50-31. If an individual receiving residential treatment services requires more than sixty days of residential treatment services, unused inpatient treatment benefits provided for under subdivision b may be traded for residential treatment benefits. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by a residential treatment program, provided that no more than twenty-three days of inpatient treatment benefits required by this section may be traded for residential treatment benefits required under this section.

26.1-36-09. Group health policy and health service contract mental disorder coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy or health service contract on a group or blanket or franchise or association basis unless the policy or contract provides benefits, of the same type offered under the policy or contract for other illnesses, for health services to any person covered under the policy or contract, for the diagnosis, evaluation, and treatment of mental disorder and other related illness, which benefits meet or exceed the benefits provided in subsection 2.
2. a. The benefits must be provided for each of the following services: inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment.

   b. In the case of benefits provided for inpatient treatment, the benefits must be provided for a minimum of forty-five days of services covered under this section and section 26.1-36-08 in any calendar year if provided by a hospital as defined under section 52-01-01 and rules of the department of health and human services pursuant thereto offering treatment for the prevention or cure of mental disorder or other related illness. An insurance provider may require an individualized treatment plan from the inpatient treatment service provider which indicates that the course of treatment is the most appropriate and least restrictive form of treatment available in the community.

   c. In the case of benefits provided for partial hospitalization, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section and section 26.1-36-08 in any calendar year. Partial hospitalization must be provided by a hospital as defined under section 52-01-01 and rules of the department of health and human services pursuant thereto or by a state-operated behavioral health clinic licensed under section 50-06-05.2, offering treatment for the prevention or cure of mental disorder or other related illness. For services provided in state-operated behavioral health clinics, charges must be reasonably similar to the charges for care provided by hospitals as defined in this subsection.

   d. In the case of benefits provided for residential treatment, the benefits must be provided for a minimum of one hundred twenty days of services covered under this section in any calendar year. Residential treatment services must be provided by a hospital as defined under section 52-01-01 and rules of the department of health and human services; by a state-operated behavioral health clinic licensed under section 50-06-05.2 offering treatment for the prevention or cure of mental disorder or other related illness; or by a residential treatment program. For services provided in a state-operated behavioral health clinic, charges must be reasonably similar to the charges for care provided by a hospital as defined in this subsection.

e. Any individual receiving residential treatment services who requires residential treatment service beyond the minimum of one hundred twenty days may trade unused inpatient treatment benefits provided for under subdivision b. For the purpose of computing the period for which benefits are payable, each day of inpatient treatment is equivalent to two days of treatment by a residential treatment program; provided, however, that no more than twenty-three days of the inpatient treatment benefits required by this section may be traded for residential treatment services.

f. (1) In the case of benefits provided for outpatient treatment, the benefits must be provided for a minimum of thirty hours for services covered under this section in any calendar year if the treatment services are provided within the scope of licensure by a nurse who holds advanced licensure with a scope of practice within mental health or if the diagnosis, evaluation, and treatment services are provided within the scope of licensure by a licensed physician, a licensed psychologist who is eligible for listing on the national register of health service providers in psychology, a licensed professional clinical counselor who is qualified in the clinical mental health counseling specialty in this state, or a licensed independent clinical social worker.

(2) A person who is qualified for third-party payment by the board of social work examiners on August 1, 1997, is exempt from paragraph 1.

(3) Upon the request of an insurance company, a nonprofit health service corporation, or a health maintenance organization, the North Dakota board of social work examiners shall provide to the requesting entity information to certify that a licensed certified social worker meets the qualifications required under this section.

(4) The insurance company, nonprofit health service corporation, or health maintenance organization may not establish a deductible or a copayment for the first five hours in any calendar year, and may not establish a copayment greater than twenty percent for the remaining hours. The deductible limitation of this paragraph does not apply to a high-deductible health plan used to establish a health savings account pursuant to and as defined in section 223 of the Internal Revenue Code [26 U.S.C. 223].

(5) If the services are provided by a provider outside a preferred provider network without a referral from within the network, the insurance company, nonprofit health service corporation, or health maintenance organization may establish a copayment greater than twenty percent for only those hours after the first five hours in any calendar year.

g. "Partial hospitalization" means continuous treatment for at least three hours, but not more than twelve hours, in any twenty-four-hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

h. "Residential treatment" has the same meaning as provided in section 25-03.2-01, but only applies to individuals under twenty-one years of age.

3. This section does not prevent any insurance company, nonprofit health service corporation, or health maintenance organization from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this section, when the policy or contract is not subject to such provisions.

26.1-36-09.1. Health insurance policy and health service contract - Mammogram examination coverage.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any person covered under the policy or contract for:

a. One baseline mammogram examination for each woman who is at least thirty-five but less than forty years of age.
b. One mammogram examination every year, or more frequently if ordered by a physician, for each woman who is at least forty years of age.

2. This section does not apply to individually guaranteed renewable supplemental, specified disease, long-term care, or other limited benefit policies.

26.1-36-09.2. Health insurance policy and health service contract - Involuntary complications of pregnancy coverage.

No insurance company, nonprofit health service corporation, or health maintenance organization may deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis if the policy, contract, or evidence of coverage contains any exclusion, reduction, or other limitation as to coverage, deductibles, or coinsurance provisions, as to involuntary complications of pregnancy, unless the provisions apply generally to all benefits paid under the policy, contract, or evidence of coverage. If a fixed amount is specified in the policy, contract, or evidence of coverage for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy must be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. If a fixed amount is payable for maternity benefits, involuntary complications of pregnancy are an illness and entitled to benefits otherwise provided by the policy, contract, or evidence of coverage. If the policy, contract, or evidence of coverage contains a maternity deductible, the maternity deductible applies only to expenses resulting from normal delivery and caesarean section delivery; however, expenses for caesarean section delivery in excess of the deductible must be treated as expenses for any other illness under the policy, contract, or evidence of coverage. For purposes of this section, "involuntary complications of pregnancy" includes nonelective caesarean section delivery.

26.1-36-09.3. Coverage for treatment of certain disorders.

Except for policies that only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or a subscriber contract provided by a nonprofit health service corporation, preferred provider organization, or health maintenance organization, may be issued, renewed, continued, delivered, issued for delivery, or executed in this state after January 1, 1990, unless the policy, certificate, plan, or contract specifically provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage must be the same as that for treatment to any other joint in the body and applies if the treatment is administered or prescribed by a physician or a dentist. Benefits for the coverage may be limited to a lifetime maximum of ten thousand dollars per person for surgery, and two thousand five hundred dollars for nonsurgical treatment.

26.1-36-09.4. Preventive health care - Copayments.

Repealed by S.L. 2013, ch. 236, § 6.

26.1-36-09.5. Service of advanced registered nurse practitioner - Direct reimbursement required.

The insured or any person covered by a health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis issued, delivered, executed, or renewed by an insurance company, nonprofit health service corporation, or health maintenance organization which provides for reimbursement or payment for services that are within the scope of practice of an advanced registered nurse practitioner who has received an advanced license under rules adopted by the North Dakota state board of nursing is entitled to reimbursement or payment for services performed by an advanced registered nurse practitioner and the advanced registered nurse practitioner is entitled to direct reimbursement by the insurer.

26.1-36-09.6. Health insurance policy and health service contract - Prostate-specific antigen test coverage.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides an annual digital rectal examination and a prostate-specific antigen test for an asymptomatic male aged fifty and over, a black male aged forty and over, and a male aged forty or over with a family history of prostate cancer.

26.1-36-09.7. Foods and food products for inherited metabolic diseases.

1. As used in this section:
   a. "Inherited metabolic disease" means maple syrup urine disease or phenylketonuria.
   b. "Low-protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a natural food that is naturally low in protein.
   c. "Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered under the direction of a physician.
2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides prescription coverage on an individual, group, blanket, franchise, or association basis, unless the policy or contract provides, for any person covered under the policy or contract, coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease.
3. This section applies to any covered individual born after December 31, 1962. This section does not require coverage in excess of three thousand dollars per year total for low-protein modified food products or medical food for an individual with an inherited metabolic disease of amino acid or organic acid.
4. This section does not require medical benefits coverage for low-protein modified food products or medical food for an individual to the extent those benefits are available to that individual under a department of health and human services program.

26.1-36-09.8. Health insurance policy and health service contract - Postdelivery coverage for mothers and newborns.

1. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides maternity benefits on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any person covered under the policy or contract for:
   a. Inpatient care for at least forty-eight hours for a mother and her newborn child following a normal vaginal delivery, and inpatient care for at least ninety-six hours following a caesarean section, without requiring the attending physician or health care provider to obtain authorization to care for a mother and her newborn child in the inpatient setting for this period of time.
   b. Inpatient care in excess of forty-eight hours following a vaginal delivery and ninety-six hours following a caesarean section if the stay is determined to be reasonable and medically necessary.

2. Coverage is not required for postdelivery inpatient care for a covered mother and her newborn child during the entire minimum time period required under subdivision a of subsection 1 if:
   a. The attending physician or health care provider, in consultation with the mother, decides to discharge the mother and her newborn child early; and
   b. The mother and her newborn child meet the minimum medical criteria for discharge as recommended in the "Guidelines for Perinatal Care" prepared by the American college of obstetricians and gynecologists and the American academy of pediatrics.
3. A person covered under this section is not required to give birth in a hospital or stay in a hospital for a fixed period of time following the birth of her child or participate in any postdelivery visit.
4. An insurance company, nonprofit health service corporation, health maintenance organization, or provider may not:
   a. Provide monetary payments to any insured person to request less than the minimum coverage required under this section;
   b. Penalize or otherwise reduce or limit the reimbursement of an attending physician or health care provider for recommending or providing care that is covered under this section;
   c. Waive any deductible, coinsurance, or copayment requirement for providing the minimum coverage required under this section;
   d. Deny to the mother or newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the plan solely to avoid the requirements of this section; or
   e. Provide incentives, monetary or otherwise, to an attending physician or health care provider to induce the physician or provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.
5. The coverage required under subsection 1 may not exceed policy aggregate limits for this coverage.
6. This section does not prevent an insurance company, nonprofit health service corporation, or health maintenance organization from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for hospital lengths of stay relating to childbirth for a mother or newborn child under the plan.

26.1-36-09.9. Dental anesthesia and hospitalization coverage.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits for anesthesia and hospitalization for dental care provided to a covered individual who is a child under age nine, is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. A carrier may require preauthorization of hospitalization for dental care procedures under this section in the same manner preauthorization is required for hospitalization for other covered diseases or conditions. Coverage under this section applies regardless of whether the services are provided in a hospital or an ambulatory surgery center.

26.1-36-09.10. Health insurance policy and health service contract - Prehospital emergency medical services.

1. In this section, unless the context or subject matter otherwise requires:
   a. "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part.

b. "Prehospital emergency medical services" means a service or its personnel either licensed under chapter 23-27 or certified by the department of health and human services.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage that provides prehospital emergency medical services benefits on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides prehospital emergency medical services benefits in the case of an emergency medical condition.
3. The coverage required under this section does not require coverage in excess of policy aggregate limits or internal policy limits dealing specifically with prehospital emergency medical services.
4. This section does not prevent an insurance company, nonprofit health service corporation, or health maintenance organization from imposing deductibles, coinsurance, or other cost sharing in relation to benefits for prehospital emergency medical services.

26.1-36-09.11. Breast reconstruction surgery.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, or franchise basis unless the policy, contract, or evidence of insurance provides the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998 [Pub. L. 105-277; 112 Stat. 2681-337; 42 U.S.C. 300gg-6]. This section does not apply to individual or group supplemental, specified disease, long-term care, or other limited benefit policies.

26.1-36-09.12. Medical services related to suicide.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any hospital, surgical, medical, or major medical benefit policy on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from suicide, attempted suicide, or self-inflicted injury. The medical benefits provided for in this section are exempt from section 54-03-28.

26.1-36-09.13. Medical services related to intoxication.

An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any major medical expense policy on a group, individual, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits, of the same type offered under the policy or contract for illnesses, for health services to any individual covered under the policy or contract for injury or illness resulting from any loss sustained or contracted in the consequence of the insured's being intoxicated or under the influence of any narcotic. The coverage required under this section may be subject to limitations under subdivision g of subsection 2 of section 26.1-36-04 or subsection 15 of section 26.1-36-05.

26.1-36-09.14. Coverage of cancer treatment medications.

1. As used in this section:
   a. "Cancer treatment medications" means prescription drugs and biologics that are used to kill, slow, or prevent the growth of cancerous cells.
   b. "Insurer" means an insurance company, nonprofit health service corporation, or health maintenance organization.
   c. "Patient-administered" includes oral administration and self-injection.
   d. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

2. An insurer may not deliver, issue, execute, or renew a policy that provides coverage for cancer treatment medications that are injected or are intravenously administered by a health care provider and that provides coverage for patient-administered cancer treatment medications unless the policy copayment, deductible, and coinsurance amounts for patient-administered cancer treatment medications do not exceed the amounts for cancer treatment medications that are injected or are intravenously administered by a health care provider, regardless of the formulation or benefit category.
3. An insurer may not increase a copayment, deductible, or coinsurance amount for covered cancer treatment medications that are injected or intravenously administered in order to avoid compliance with subsection 2. An insurer may not reclassify benefits with respect to cancer treatment medications in a manner that is inconsistent with this section.

26.1-36-09.15. Coverage of telehealth services.

1. As used in this section:
   a. "Distant site" means a site at which a health care provider or health care facility is located while providing medical services by means of telehealth.
   b. "E-visit" means a face-to-face digital communication initiated by a patient to a provider through the provider's online patient portal.
   c. "Health care facility" means any office or institution at which health services are provided. The term includes hospitals; clinics; ambulatory surgery centers; outpatient care facilities; nursing homes; nursing, basic, long-term, or assisted living facilities; laboratories; and offices of any health care provider.
   d. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.
   e. "Nonpublic facing product" means a remote communication product that, as a default, allows only the intended parties to participate in the communication.
   f. "Originating site" means a site at which a patient is located at the time health services are provided to the patient by means of telehealth.
   g. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.
   h. "Secure connection" means a connection made using a nonpublic facing remote communication product that employs end-to-end encryption, and which allows only an individual and the person with whom the individual is communicating to see what is transmitted.
   i. "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a distant site at a later date by a health care provider or health care facility without the patient present in real time. The term includes telehome monitoring and interactive audio, video, and data communication.
   j. "Telehealth":
      (1) Means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws.
      (2) Includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
      (3) Does not include the use of electronic mail, facsimile transmissions, or audio-only telephone unless for the purpose of e-visits or a virtual check-in.

k. "Virtual check-in" means a brief communication via telephone or other telecommunications device to decide whether an office visit or other service is needed.

2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.
3. Payment or reimbursement of expenses for covered health services delivered by means of telehealth under this section may be established through negotiations conducted by the insurer with the health services providers in the same manner as the insurer establishes payment or reimbursement of expenses for covered health services that are delivered by in-person means.
4. Coverage under this section may be subject to deductible, coinsurance, and copayment provisions.
5. This section does not require:
   a. A policy to provide coverage for health services that are not medically necessary, subject to the terms and conditions of the policy;
   b. A policy to provide coverage for health services delivered by means of telehealth if the policy would not provide coverage for the health services if delivered by in-person means;
   c. A policy to reimburse a health care provider or health care facility for expenses for health services delivered by means of telehealth if the policy would not reimburse that health care provider or health care facility if the health services had been delivered by in-person means; or
   d. A health care provider to be physically present with a patient at the originating site unless the health care provider who is delivering health services by means of telehealth determines the presence of a health care provider is necessary.

26.1-36-09.16. Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations.

1. As used in this section:
   a. "Health benefit plan" has the same meaning as in section 26.1-36.3-01.
   b. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:
      (1) Rapid-acting insulin;
      (2) Short-acting insulin;
      (3) Intermediate-acting insulin;
      (4) Long-acting insulin;
      (5) Premixed insulin product;
      (6) Premixed insulin/GLP-1 RA product; and
      (7) Concentrated human regular insulin.
   c. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:
      (1) Blood glucose meters;
      (2) Blood glucose test strips;
      (3) Lancing devices and lancets;
      (4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;
      (5) Glucagon, in injectable and nasal forms;

(6) Insulin pen needles; and
(7) Insulin syringes.

d. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a prescription.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health benefit plan unless the health benefit plan provides benefits for insulin drug and medical supplies for insulin dosing and administration which complies with this section.
3. The health benefit plan must limit out-of-pocket costs for a thirty-day supply of:
   a. Covered insulin drugs, which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.
   b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.
4. The health benefit plan may not allow a pharmacy benefits manager or the pharmacy or distributor to charge a covered individual, require the pharmacy or distributor to collect from a covered individual, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount exceeding the out-of-pocket limits under subsection 3.
5. The health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount under subsection 3.
6. Subsection 3 does not require the health benefit plan to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. This section does not limit whether the health benefit plan classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.
7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has met the minimum deductible under section 26 U.S.C. 223.
8. This section does not apply to the Medicare part D prescription drug coverage plan.

26.1-36-09.17. Out-of-pocket expenses - Prescription drugs.

1. As used in this section:
   a. "Cost-sharing" means any coinsurance, copayment, or deductible under a health benefit plan.
   b. "Enrollee" means an individual entitled to prescription drug coverage under a health benefit plan.
   c. "Health benefit plan" has the same meaning as provided under section 26.1-36.3-01.
   d. "Prescription drug" means a drug for which a prescription is required:
      (1) Without a generic equivalent; or
      (2) With a generic equivalent, if the enrollee has obtained access to the drug through prior authorization, a step therapy protocol, or the heath care insurer's expectations and appeals process.
2. To the extent permitted by federal law and regulation, an insurer may not deliver, issue, execute, or renew a health benefit plan providing prescription drug coverage unless when calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement for a prescription drug under the health benefit plan, the health benefit plan provides for the inclusion of any amount paid by the enrollee or paid on behalf of the enrollee by another person. The health benefit

plan may not vary the out-of-pocket maximum or cost-sharing requirement, or otherwise design benefits accounting for the availability of a cost-sharing assistance program for a prescription drug.

3. If application of this section would result in ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of this section do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.

26.1-36-10. Health policy and health service contract coordination of benefit provisions.

A group health insurance policy or a group health service contract may contain coordination of benefit provisions for the control of overinsurance. An individual health insurance policy or individual health service contract, except a specific disease, hospital indemnity, or other limited benefit plan, may contain coordination of benefit provisions for the control of overinsurance. These provisions must be in accordance with appropriate guidelines set forth in rules adopted by the commissioner.

26.1-36-11. Accident and health policy provision denying insured right to employ doctor or enter hospital prohibited.

Any provision in any accident or health insurance policy issued by any insurance company denying the insured, in case of accident or sickness, the right to consult or employ any doctor licensed to practice in this state the insured may choose, or to enter any hospital or sanitarium organized and operating under the laws of this state the insured may select is void. The insurance company shall recognize any proof of claim duly certified by such doctor or hospital or sanitarium notwithstanding any provision contained in the policy.

26.1-36-12. Provisions prohibited in individual and group accident and health insurance policies, group health plans, and nonprofit health service contracts.

1. Any provision in any individual or group accident and health insurance policy, employee welfare benefit plan, or nonprofit health service contract issued by any insurance company, group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [Pub. L. 99-272; 100 Stat. 281; 29 U.S.C. 1167(1)], or nonprofit health service corporation denying or prohibiting the insured, participant, beneficiary, or subscriber from assigning to the department of health and human services any rights to medical benefits coverage to which the insured, participant, beneficiary, or subscriber is entitled under the policy, plan, or contract is void. An individual or group insurance company or nonprofit health service corporation shall recognize the assignment of medical benefits coverage completed by the insured, participant, beneficiary, or subscriber, notwithstanding any provision contained in the policy or contract to the contrary.
2. Any individual or group provision in any accident and health insurance policy, employee welfare benefit plan, or nonprofit health service corporation contract issued by any insurance company, group health plan, or nonprofit health service corporation which limits or excludes payments of medical benefits coverage to or on behalf of the insured, participant, beneficiary, or subscriber if the insured, participant, beneficiary, or subscriber is eligible for medical assistance benefits under chapter 50-24.1 is void.

26.1-36-12.1. Health service corporation contract provision denying insured or subscriber right to employ doctor or enter hospital prohibited.

Any provision in any health service contract issued by a health service corporation denying the insured or subscriber, subscriber member, officer, or employee, in case of accident or sickness, the right to consult or employ any doctor, including doctors of chiropractic, licensed to practice in this state whom the insured, subscriber, subscriber member, officer, or employee may choose, or to enter any hospital or sanitarium organized and operating under the laws of

this state which the insured, subscriber, subscriber member, officer, or employee may select, is void. The health service corporation must recognize any proof of claim duly certified by the doctor, hospital, or sanitarium notwithstanding any provision contained in the contract.

26.1-36-12.2. Freedom of choice for pharmacy services.

1. No third-party payer, including a health care insurer as defined in section 26.1-47-01, providing pharmacy services and prescription drugs to any beneficiary may:
   a. Prevent a beneficiary from selecting the pharmacy or pharmacist of the beneficiary's choice to provide pharmaceutical goods and services, provided that pharmacist or pharmacy is licensed in this state;
   b. Impose upon any beneficiary selecting a participating or contracting provider a copayment, fee, or other condition not equally imposed upon all beneficiaries in the plan selecting a participating or contracting provider; or
   c. Deny any pharmacy or pharmacist the right to participate as a preferred provider under chapter 26.1-47 or as a contracting provider for any policy or plan, provided the pharmacist or pharmacy is licensed in this state, and accepts the terms of the third-party payer's contract.
2. Notwithstanding the provisions of subsection 1, the department of health and human services may exclude, from participation in the medical assistance program administered under chapter 50-24.1 and title XIX of the Social Security Act [Pub. L. 89-97; 79 Stat. 343; 42 U.S.C. 1396 et seq.], as amended, any provider of pharmacy services who does not agree to comply with state and federal requirements governing the program, or who, after so agreeing, fails to comply with those requirements.
3. Any provision in a health insurance policy in this state which violates the provisions in subsection 1 is void.
4. Any person who violates this section is guilty of a class A misdemeanor and each violation is a separate offense. The commissioner may levy an administrative penalty not to exceed ten thousand dollars for a violation of this section.
5. The insurance commissioner shall enforce the provisions of this section.

26.1-36-12.3. Basic health insurance coverage - Exception to required coverages.

Expired under S.L. 1991, ch. 319, § 3.

26.1-36-12.4. Confidentiality of medical information.

1. An insurance company, as defined in section 26.1-02-01, health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not deliver, issue, execute, or renew a health insurance policy or health service contract unless confidentiality of medical information is assured pursuant to this section. An insurer shall adopt and maintain procedures to ensure that all identifiable information maintained by the insurer regarding the health, diagnosis, and treatment of persons covered under a policy or contract is adequately protected and remains confidential in compliance with all federal and state laws and regulations and professional ethical standards. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a person covered under a policy or contract, or a prospective insured, obtained by an insurer from that person or from a health care provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except:
   a. If the data or information identifies the covered person or prospective insured upon a written, dated, and signed approval by the covered person or prospective insured, or by a person authorized to provide consent pursuant to section 23-12-13 for a minor or an incapacitated person;
   b. If the data or information identifies the health care provider upon a written, dated, and signed approval by the provider. However, this subdivision may not be

construed to prohibit an insurer from disclosing data or information pursuant to chapter 23-01.1 or from disclosing, as part of a contract or agreement in which the health care provider is a party, data or information that identifies a provider as part of mutually agreed-upon terms and conditions of the contract or agreement;

c. If the data or information does not identify either the covered person or prospective insured or the health care provider, the data or information may be disclosed upon request for use for statistical purposes or research;

d. Pursuant to statute or court order for the production or discovery of evidence; or

e. In the event of a claim or litigation between the covered person or prospective insured and the insurer in which the data or information is pertinent.

2. An insurer may claim any statutory privileges against disclosure that the health care provider who furnished the information to the insurer is entitled to claim.

3. This section may not be construed to prevent disclosure necessary for an insurer to conduct utilization review or management consistent with the standards imposed by chapter 26.1-26.4, to facilitate payment of a claim, to analyze health plan claims or health care records data, to conduct disease management programs with health care providers, or to reconcile or verify claims under a shared risk or capitation arrangement. This section does not apply to data or information disclosed by an insurer as part of a biomedical research project approved by an institutional review board established under federal law. Nor may this section be construed to limit the insurance commissioner's access to records of the insurer for purposes of enforcement or other activities related to compliance with state or federal laws; however, medical records acquired by the commissioner as part of an examination of an insurer's business practices under section 26.1-03-19.2 or any other regulatory action or proceeding commenced by the commissioner are confidential.

26.1-36-12.5. Basic health insurance coverage - Exceptions to required coverage.

1. An insurance company, a nonprofit health service corporation, or a health maintenance organization may deliver, issue, execute, and renew a basic health insurance policy, health service contract, or evidence of coverage on an individual basis or an employer group, blanket, franchise, or association basis for employers with fewer than fifty employees.

2. The basic health insurance coverage policy, contract, or evidence of coverage under this section is not subject to sections 26.1-36-06.1, 26.1-36-08, 26.1-36-09.1, 26.1-36-09.3, 26.1-36-09.6, 26.1-36-09.7, 26.1-36-09.9, 26.1-36-09.10, 26.1-36-12.1, and 43-13-31. However, the insurance company, nonprofit health service corporation, or health maintenance organization shall make the coverage required under these sections available at the option of the individual or employer and may charge an additional premium for each coverage provided.

3. Any law that becomes effective after January 1, 2001, which provides for an accident and health insurance coverage mandate does not apply to a basic health insurance policy issued under this section unless the law specifically identifies application to a basic health insurance coverage policy.

26.1-36-12.6. Ambulance services classifications.

For purposes of classifying ambulance services for an accident and health insurance policy, the classifications established under section 50-24.1-16 apply.

26.1-36-12.7. Freedom of choice for health care services.

1. As used in this section:

a. "Health benefit plan" has the same meaning as provided in section 26.1-36.3-01.

b. "Health care provider" includes an individual licensed under chapter 43-05, 43-06, 43-12.1 as a registered nurse or as an advanced practice registered nurse, 43-13, 43-15, 43-17, 43-26.1, 43-28, 43-32, 43-37, 43-40, 43-41, 43-42, 43-44, 43-45, 43-47, 43-58, or 43-60.

c. "Integrated delivery network" means a system of health care providers and facilities which offer both health care services and health benefit plans.

2. A health insurer, including the Medicaid program, which is part of an integrated delivery network may not obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation, as established by the health insurer.

26.1-36-13. Applicability of accident and health policy simplification standards.

1. Except as provided in subsection 3, sections 26.1-36-13 through 26.1-36-16 apply to all individual and group accident and health insurance contracts, policies, plans, or agreements, insurance certificates under group accident and health insurance policies, and disability benefit certificates issued by fraternal benefit societies filed after June 30, 1982. No policy may be delivered or issued for delivery in this state after June 30, 1986, unless approved by the commissioner or permitted to be issued under sections 26.1-36-13 through 26.1-36-16. Any policy form that has been approved or permitted to be issued prior to July 1, 1986, and that meets the standards set by sections 26.1-36-13 through 26.1-36-16 need not be refiled for approval, but may continue to be delivered or issued for delivery in this state upon the filing with the commissioner of a list of the forms identified by form number and accompanied by a certificate as to each such form in the manner provided in subsection 6 of section 26.1-36-14.
2. The commissioner may extend the dates in subsection 1.
3. Sections 26.1-36-13 through 26.1-36-16 do not apply to:
   a. A policy that is a security subject to federal jurisdiction.
   b. Any group policy covering a group of one thousand or more lives at date of issue. However, this does not except any certificate issued pursuant to a group policy delivered or issued for delivery in this state.
   c. A form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under sections 26.1-36-13 through 26.1-36-16.
   d. The renewal of a policy delivered or issued for delivery prior to the dates the forms must be approved under sections 26.1-36-13 through 26.1-36-16.
4. No other state law setting language simplification standards applies to a policy form.

26.1-36-14. Minimum accident and health policy language simplification standards.

1. No policy form may be delivered or issued for delivery in this state unless:
   a. The text achieves a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection 3.
   b. It is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one point leaded.
   c. The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsement or rider.
   d. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than three thousand words printed or three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.
2. The commissioner may authorize a lower score than the Flesch reading ease score required in subdivision a of subsection 1 whenever the commissioner finds that a lower score:
   a. Will provide a more accurate reflection of the readability of a policy form.
   b. Is warranted by the nature of a particular policy form or type or class of policy forms.
   c. Is caused by certain policy language which is drafted to conform to the requirements of any state law or rule, or agency interpretation.

3. A Flesch reading ease test score is measured by the following method:
   a. For policy forms containing ten thousand words or less of text, the entire form must be analyzed. For policy forms containing more than ten thousand words, the readability of two 200-word samples per page may be analyzed instead of the entire form. The samples must be separated by at least twenty printed lines.
   b. The number of words and sentences in the text must be counted and the total number of words divided by the total number of sentences. The figure obtained must be multiplied by a factor of one and fifteen thousandths.
   c. The total number of syllables must be counted and divided by the total number of words. The figure obtained must be multiplied by a factor of eighty-four and six-tenths.
   d. The sum of the figures computed under subdivisions b and c subtracted from two hundred six and eight hundred thirty-five thousandths equals the Flesch reading ease score for the policy form.
   e. For purposes of subdivisions b, c, and d, the following procedures must be used:
      (1) A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word.
      (2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence.
      (3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. When the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.
4. As used in this section, "text" includes all printed matter except:
   a. The name and address of the insurer, the name, number, or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules, and tables.
   b. Any policy language drafted to conform to the requirements of any federal law, regulation, or agency interpretation, any policy language required by any collectively bargained agreement, any medical terminology, any words defined in the policy, and any policy language required by law or rule, provided, however, the insurer identifies the language or terminology excepted by this subdivision and certifies, in writing, that the language or terminology is entitled to be excepted by this subdivision.
5. The commissioner may approve any other reading test for use as an alternative to the Flesch reading ease test if the other test is comparable in result to the Flesch reading ease test.
6. Filings subject to this section must provide the minimum reading ease score or a statement that the score is lower than the minimum required but should be approved in accordance with subsection 2. To confirm the accuracy of any statement, the commissioner may require the submission of further information to verify the certification in question.
7. At the option of the insurance company, nonprofit health service corporation, fraternal benefit society, or health maintenance organization, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

26.1-36-15. Approval of accident and health policy forms.

A policy form meeting the requirements of subsection 1 of section 26.1-36-14 must be approved notwithstanding any other law which specifies the contents of a policy, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws.

26.1-36-16. Effect of accident and health policy simplification standards on filed policies.

Sections 26.1-36-13 through 26.1-36-15 do not negate any law of this state permitting the issuance of a policy form after it has been on file for the required time period and has not been disapproved by the commissioner.

26.1-36-17. Application for accident and health policy.

1. The insured is not bound by any statement made in an application for an accident and health insurance policy unless a copy of the application is attached to or endorsed on the policy. If any policy delivered or issued for delivery to any person in this state is to be reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for reinstatement or renewal, the insurer, within fifteen days after the receipt of the request at its home office or any branch office of the insurer, shall deliver or mail to the person making the request a copy of the application. If the copy is not delivered or mailed, the insurer is precluded from introducing the application as evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal.
2. No alteration of any written application for an accident and health insurance policy may be made by any person other than the applicant without the applicant's written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that the insertions are not to be ascribed to the applicant.
3. The falsity of any statement in the application for an accident and health insurance policy may not bar the right to recovery under the policy unless the false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

26.1-36-18. Notice under accident and health policy - Waiver.

The acknowledgment by any insurer of the receipt of notice given under an accident or health insurance policy, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim does not operate as a waiver of any of the rights of the insurer in defense of any claim arising under the policy.

26.1-36-19. Age limit in accident and health policy.

If an accident and health insurance policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if the date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after that date, the coverage provided by the policy continues in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer is limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

26.1-36-20. Juvenile's accident and health coverage to continue - Conditions.

Insurance companies and nonprofit health service corporations licensed in this state shall continue coverage of a juvenile insured under an accident and health insurance policy or a health service contract while the legal custody of the juvenile has been given by a court, under chapters 27-20.3 and 27-20.4, to any public institution or agency, to the same extent as the general public is covered as long as the juvenile meets all the other usual qualifications for insurability and continues to pay the policy or contract premiums. A juvenile's incarceration may not be a basis for cancellation of the juvenile's accident and health insurance policy or health service contract.

26.1-36-21. Prisoner's accident and health coverage to continue - Conditions.

Insurance companies and nonprofit health service corporations licensed in this state shall continue coverage of a prisoner insured under an accident and health insurance policy or a health service contract while the prisoner is incarcerated and under state supervision to the same extent as the general public is covered as long as the prisoner meets all the other usual qualifications for insurability and continues to pay the policy or contract premiums. A prisoner's incarceration may not be a basis for cancellation of the prisoner's accident and health insurance policy or health service contract.

26.1-36-22. Individual and group health insurance for dependents.

An individual or group health insurance policy may be extended to insure the individuals, employees, or members with respect to their family members or dependents, including dependents of dependents, or any class or classes thereof, subject to the following:

1. The premium for the insurance must be paid either from funds contributed by the employer, union, association, or other person to whom the policy has been issued, or from funds contributed by the covered persons, or from both. A policy on which no part of the premium for the family members or dependents coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof.
2. An insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.
3. A policy that provides coverage for a dependent child of an employee or other member of the covered group must provide such coverage up to a limiting age of twenty-two years of age, if the dependent child physically resides with the employee or other member and is chiefly dependent upon the employee or member for support and maintenance.
4. A policy that provides that coverage for a dependent child of an employee or other member of the covered group terminates upon attainment of the limiting age for dependent children specified in the policy does not operate to terminate the coverage of a dependent child while the child is a full-time student and has not attained the age of twenty-six years or while the child is and continues to be both incapable of self-sustaining employment by reason of intellectual disability or physical disability and chiefly dependent upon the employee or member for support and maintenance, provided proof of incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

26.1-36-23. Continuation of group hospital, surgical, and major medical coverage after termination of employment or membership.

A group policy or certificate of insurance or certificate on a master policy of a group as defined by subsection 6 of section 26.1-02-05 delivered or issued for delivery in this state issued by any insurance company, nonprofit health service corporation, health maintenance organization, or any other insurer that provides hospital, surgical, or major medical expense insurance or any accommodation of these coverages on an expense-incurred basis, but not a policy that provides benefits for specific diseases or for accidental injuries only, must provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership are entitled to continue their hospital, surgical, and major medical insurance under that group policy, for themselves and their eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

1. Continuation is only available to an employee or member who has been continuously insured under the group policy, and for similar benefits under any group policy which it replaced, during the entire three-month period ending with the termination.

2. Continuation is not available for any person who is covered by Medicare. Neither is continuation available for any person who is covered by any other insured or uninsured arrangement which provides hospital, surgical, or medical coverages for individuals in a group and under which the person was not covered immediately prior to the termination.
3. Continuation need not include dental, vision care, or prescription drug benefits or any other benefits provided under the group policy in addition to its hospital, surgical, or major medical benefits.
4. An employee or member who wishes continuation of coverage must request the continuation in writing within the ten-day period following the later of the date of termination, or the day the employee is given notice of the right of continuation by either the employer or the group policyholder. The employee or member may not elect continuation more than thirty-one days after the date of termination.
5. An employee or member electing continuation shall pay to the group policyholder or the employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than the group rate for the insurance being continued under the group policy on the due date of each payment. The employee's or member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within thirty-one days of the date the employee's or member's insurance would otherwise terminate.
6. Continuation of insurance under the group policy for any person terminates when the person fails to satisfy subsection 2 or, if earlier, at the first to occur of the following:
    a. The date thirty-nine weeks after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.
    b. If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.
    c. The date on which the group policy is terminated or, in the case of an employee, the date the employer terminates participation under the group policy. However, if this subdivision applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following apply:
        (1) The employee or member may become covered under that other group policy for the balance of the period that the employee or member would have remained covered under the prior group policy in accordance with this subsection had a termination described in this subdivision not occurred.
        (2) The minimum level of benefits to be provided by the other group policy is the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy.
        (3) The prior group policy must continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.
7. A notification of the continuation privilege must be included in each certificate of coverage.
8. Upon termination of the continuation period, the member, surviving spouse, or dependent is entitled to exercise any option which is provided in the group plan to elect a conversion policy. The member electing a conversion policy shall notify the carrier of the election and pay the required premium within thirty-one days of the termination of the continued coverage under the group contract.
9. a. Notwithstanding any other provision of this section, an employee or member who does not have an election of continuation coverage as described in this section in effect on the effective date of the American Recovery and Reinvestment Act of 2009 [Pub. L. 111-5], but who would be an assistance-eligible individual under title III of division B of the Act if the election were in effect, may elect continuation coverage. The employer or the group policyholder shall provide employees or members with additional written notice of the right to elect coverage under this

subsection within sixty days of the date of enactment of the American Recovery and Reinvestment Act of 2009 or May 19, 2009, whichever is later. The employee or member may make the election in writing no later than sixty days after the date the employer or the group policyholder provides the notice to the employee or member.

b. Continuation coverage elected under this subsection commences with the first period of coverage beginning after February 16, 2009, and may not extend beyond the period of continuation coverage that would have been required if the coverage had instead been elected under subsection 4.

c. The period beginning on the date that the employee or member was involuntarily terminated and ending when the continuation coverage starts must be disregarded for the purpose of determining whether a pre-existing condition exclusion period applies.

d. An employee or member electing continuation under this subsection shall pay to the group policyholder or the employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than the group rate for the insurance being continued under the group policy on the due date of each payment. The employee's or member's written election of continuation, together with the contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within thirty-one days of the date the employee's or member's election of continuation coverage.

e. Continuation of insurance under this subsection terminates at the earlier of the date when the person fails to satisfy subsection 2 or when the person fails to satisfy any requirement of subsection 6.

f. The notification described in subsection 7 is not required for continuation coverage elected under this subsection.

g. Except as otherwise provided in this subsection, the provisions of this section apply to an employee or member electing continuation coverage.

26.1-36-23.1. Former spouse's and dependent children's accident and health coverage to continue - Conditions.

1. No group accident and health insurance policy, including a policy issued under a self-insured plan, group health service contract issued under chapter 26.1-17, or evidence of coverage issued under chapter 26.1-18.1, providing coverage for hospital or medical expenses, delivered, issued for delivery, renewed, or amended after July 1, 1987, which in addition to covering the insured also provides coverage to the spouse of the insured, may contain a provision for termination of coverage for a spouse covered under the policy, contract, or evidence of coverage solely as a result of a break in the marital relationship except by reason of an entry of a decree of annulment of marriage or divorce.
2. Every policy, contract, or evidence of coverage described in subsection 1 must contain a provision that permits continuation of coverage of the insured's former spouse and dependent children upon entry of a decree of annulment of marriage or divorce, if the decree requires the insured to provide continued coverage for those persons. The coverage may be continued until the date of remarriage of the insured's former spouse or the date coverage would otherwise terminate, whichever occurs first, but not to exceed thirty-six months. The insured shall pay any required premium contributions for the coverage not to exceed one hundred two percent of the premium for the group coverage.
3. Every policy, contract, or evidence of coverage described in subsection 1 must contain a provision allowing a former spouse and dependent children, without providing evidence of insurability, to obtain from the insurer at the expiration of any continuation of coverage under subsection 2 or upon termination of coverage by reason of an entry of a decree of annulment or divorce which does not require the insured to provide continued coverage for the former spouse and dependent children, conversion

coverage providing comparable benefits of the group policy, contract, or evidence of coverage, if an application is made to the insurer within thirty days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. A policy, contract, or evidence of coverage providing reduced benefits at a reduced premium rate may be accepted by the former spouse and dependent children in lieu of the existing coverage. The policy, contract, or evidence of coverage must be renewable at the option of the former spouse as long as the former spouse is not covered under another accident and health insurance plan, policy, or contract, up to age sixty-five or to the day before the date of eligibility for coverage under title XVIII of the Social Security Act [42 U.S.C. 1305 et seq.], as amended.

26.1-36-24. Health policy transferable.

A health insurance policy may pass by transfer, will, or succession to any person, whether that person has an insurable interest or not, and that person may recover any benefit payable under the policy in accordance with the terms of the policy, but in no event shall such transfer or succession operate to change the named insured or insureds covered under the policy. An insured under a group health insurance policy, pursuant to agreement among the insured, the group policyholder and the insurer, may make an assignment of all or any part of the incidents of ownership held by the insured under the policy, including any right to designate a beneficiary and any right to have an individual policy issued in case of termination of employment. An assignment, whether made prior to or subsequent to July 1, 1971, is valid for the purpose of vesting in the assignee all the incidents of ownership assigned, and entitles the insurer to deal with the assignee as the owner in accordance with the policy, but without prejudice to the insurer on account of any payment made or individual policy issued prior to receipt by the insurer of such notice as may be required by the policy.

26.1-36-25. Notice of transfer of health policy unnecessary - Exception.

Notice to an insurer of a transfer or bequest of a health insurance policy is not necessary to preserve the validity of the policy unless notice is required by the policy.

26.1-36-26. Dual choice option on group health coverage - Minimum conditions - Transfer of coverage.

If an existing or prospective employer group desires a dual choice option between a nonprofit health service corporation or an insurance company and a health maintenance organization, the dual choice option may be made available to the employees in the group only if all of the following conditions are met:

1. There are at least fifteen employees in the group.
2. The group shall maintain the highest enrollment percentage as specified in the underwriting manual of the nonprofit health service corporation, the insurance company, or the health maintenance organization, and the health maintenance organization enrollees must be combined with subscribers of nonprofit health service corporations or insureds of insurance companies in meeting the percentage requirements.
3. An employee must be allowed to transfer between coverage offered by a health maintenance organization and coverage offered by a nonprofit health service organization or insurance company on the group's anniversary date as specified in the master contract with the group, except a special opening must be offered at the group's request for the following reasons:
    a. Upon a group's initial offering of a dual choice plan in addition to existing coverages offered by a nonprofit health service corporation or an insurance company.
    b. When a group discontinues offering a dual choice plan with a health maintenance organization to request open enrollment into the group offered by the nonprofit health service corporation or the insurance company.

c. If the group offers both coverage by a nonprofit health service corporation or an insurance company and a health maintenance organization and an individual employee enrolled in the health maintenance organization transfers within the same company but leaves the service area of the health maintenance organization, the employee must be allowed to enroll in the plan offered by the nonprofit health service corporation or the insurance company at the time of transfer.

d. Any group that offers health coverage to its retired employees by a nonprofit health service corporation or an insurance company and a health maintenance organization must advise the employees who are enrolled under their present coverage that they may change to other coverage offered at the time of retirement, and if the employees who retire elect to retain or change their present coverage, the employees will no longer be eligible to change coverage after retirement.

26.1-36-27. Dual choice option on group health coverage - Continuous coverage - Payment of benefits.

If an employee, or an eligible dependent of the employee, transfers from coverage provided by a nonprofit health service corporation or an insurance company to coverage offered by a health maintenance organization or transfers from coverage offered by a health maintenance organization to coverage offered by a nonprofit health service corporation or an insurance company and is an inpatient of a hospital or alcoholism treatment center on the day the coverage becomes effective, then the benefits for confinement on an inpatient basis of a hospital or alcoholism treatment center must be provided by the nonprofit health service corporation, insurance company, or health maintenance organization providing coverage on the date the employee or the eligible dependent of the employee was confined as an inpatient of a hospital or alcoholism treatment center so long as coverage is uninterrupted, medically necessary, and directly related to the inpatient's stay.

26.1-36-28. Measure of indemnity in health policy.

Unless the interest of a person insured is susceptible of exact pecuniary measurement, the measure of indemnity under a health insurance policy is the sum fixed in the policy.

26.1-36-29. Coordination of benefits in individual and group accident and health policies - Limitations.

An insurer or health service corporation may not issue or renew any individual or group accident and health insurance policy that excludes or reduces the benefits payable or services to be rendered to or on behalf of any insured because benefits have been paid or are also payable under any individually underwritten and individually issued contract or plan of insurance which provides exclusively for specific disease, hospital indemnity, and other limited benefits, irrespective of the mode or channel of premium payment, with or without payroll deduction, to the insurer and regardless of any reduction in the premium by virtue of the insured's membership in any organization or of the insured's status as an employee. This section does not affect the practice of coordination of benefits as provided in section 26.1-36-10.

26.1-36-30. Individual or group accident and health insurer or nonprofit health service corporation responsibility - Release of information to department of health and human services.

1. Any individual or group accident and health insurer or nonprofit health service corporation, upon request of the department of health and human services, shall provide any information contained in its records pertaining to an individual who is an applicant for or recipient of medical assistance under chapter 50-24.1, and who is covered under an accident and health insurance policy or a health service contract issued by the insurer or nonprofit health service corporation or the medical benefits paid by or claims paid to the insured or subscriber under a policy or contract. The

insurer or nonprofit health service corporation shall make the requested records or information available upon receipt of a certification by the department of health and human services that the individual is an applicant for or recipient of medical assistance under chapter 50-24.1, or is a person who is legally responsible for the applicant or recipient.

2. The information required to be made available pursuant to this section is limited to information necessary to determine whether benefits under the policy or contract have been or should have been claimed and paid pursuant to an accident and health insurance policy or health service contract with respect to items of medical care and services received by a particular individual for which medical assistance coverage would otherwise be available.
3. The department of health and human services shall, in consultation with the commissioner, establish guidelines:
   a. For the method of requesting and furnishing appropriate information, the time in which the information is to be provided, and method of reimbursing insurance companies and nonprofit health service corporations for necessary costs incurred in furnishing the requested information.
   b. To assure that information relating to an individual certified to be an applicant for or recipient of medical assistance under chapter 50-24.1, furnished to an insurer or subscriber pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate section 50-06-15.

26.1-36-31. Medicare supplement policies - Definitions.
Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-32. Standards for Medicare supplement policies.
Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-33. Medicare supplement policy benefit standards.
Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-34. Medicare supplement policy loss ratio standards.
Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-35. Medicare supplement policy disclosure standards.
Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-36. Medicare supplement policies - Notice of free examination.
Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-36.1. Filing requirements for advertising.
Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-36.2. Noncustodial care coverage.
An insurer offering convalescent nursing home, extended care facility, or skilled nursing facility coverage under chapter 26.1-36.1 or 26.1-45 shall cover intermediate care confinements in the same manner as skilled care confinements.

26.1-36-37. Nursing home policy - Guaranteed renewable for life - Limitation on pre-existing conditions.
Repealed by S.L. 1991, ch. 304, § 14.

26.1-36-37.1. Standard health insurance proof of loss form - Claim payment time limits.

The commissioner shall prescribe by rule a standard health insurance proof of loss and claim form for use in filing proof of loss and a claim for all health care services. For purposes of this section, "health care service" means any service included in providing an individual with medical, dental, or hospital care or any service incident to providing medical, dental, or hospital care as well as any service provided to prevent, alleviate, care, or heal human illness or injury. After receipt of a health insurance proof of loss form, the insurer shall, within fifteen business days, pay the claim or that portion of the claim that is not contested, deny the claim, or make an initial request for additional information. If a claim or a portion of a claim is contested, the insured or the insured's assignee must be notified in writing that the claim is contested and the reasons for the contest. Nothing in this notification precludes the insurer from denying the claim in whole or in part, for other reasons at a later date. Within fifteen business days of the receipt of the information initially requested, the insurer shall pay or deny the claim.

26.1-36-37.2. Loss ratios - Rules.

For all policies providing hospital, surgical, medical, or major medical benefit, an insurance company, a nonprofit health service corporation, a fraternal benefit society, and any other entity providing a plan of health insurance or health benefit subject to state insurance regulation shall return benefits to group policyholders in the aggregate of not less than seventy percent of premium received and to individual policyholders in the aggregate of not less than fifty-five percent of premium received. The commissioner shall adopt rules to establish these minimum standards on the basis of incurred claims experienced and earned premiums for the entire period for which rates are computed to provide coverage in accordance with accepted actuarial principles and practices. This section does not apply to any contract or plan of insurance that provides exclusively for accident, disability income insurance, specified disease, hospital confinement indemnity, or other limited benefit health insurance.

26.1-36-38. Rulemaking authority.

The commissioner may adopt reasonable rules necessary, proper, or advisable to administer this chapter.

26.1-36-39. Effect of policy not conforming to chapter.

A policy delivered or issued for delivery to any person in this state in violation of this chapter is valid but must be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary are governed by this chapter.

26.1-36-40. General penalty - License suspension or revocation.

Any person willfully violating any provision of this chapter or order of the commissioner made in accordance with this chapter is guilty of a class A misdemeanor. The commissioner may also suspend or revoke the license of an insurer or insurance producer for any such willful violation.

26.1-36-41. Contract limitations.

1. An insurance company as defined by section 26.1-02-01 issuing a health and accident policy, a health maintenance organization, or any other entity providing a plan of health insurance subject to state insurance regulation may not terminate a practitioner's participating contract, designate a practitioner as nonpayable, or otherwise impose sanctions on any practitioner solely for an excessive or inappropriate practice pattern unless the requirements of this section are met. If a practitioner engages in an excessive or inappropriate practice pattern for the practitioner's specialty, the entity shall inform the practitioner, in writing, as to the manner in which the practitioner's practice is excessive or inappropriate. The entity shall consult with the practitioner and provide a reasonable time period of not less than six months within which to modify the

practitioner's practice pattern. If the excessive or inappropriate practice pattern continues, the entity may impose reasonable sanctions on the practitioner, terminate the practitioner's participating contract, or designate the practitioner as nonpayable. If considered for sanction, termination, or nonpayable status, the affected practitioner must first be given the opportunity to be present and to be heard by a committee appointed by the entity which must include at least one representative of the practitioner's specialty. The entity may not impose sanctions on a practitioner, terminate a practitioner, or designate a practitioner as nonpayable in the absence of the committee's recommendation to do so. All reports, practice profiles, data, and proceedings of the entity relative to a practitioner who is sanctioned, terminated, or considered for designation as nonpayable are confidential and may not be disclosed or be subject to subpoena or other legal process. Nonpayable status under this section may not commence until after appropriate notification to the entity's subscribers and the affected practitioner. As used in this section, "practitioner" includes an optometrist, a physician, a chiropractor, or an advanced registered nurse practitioner duly licensed to practice in this state.

2. If the entity uses a practice profile as a factor to evaluate a practitioner's practice pattern, the entity shall provide upon request of the practitioner at any time a description of the criteria, data sources, and methodologies used to compile the practice profile concerning the practitioner and the manner in which the practice profile is used to evaluate the practitioner. An entity may not sanction a practitioner, terminate a practitioner's participating contract, or designate a practitioner as nonpayable on the basis of a practice profile without informing the practitioner of the specific data underlying those findings. For purposes of this section, a "practice profile" means a profile, summary, economic analysis, or other analysis of data concerning the cost, quality, or quantity of services rendered by an individual practitioner, group of practitioners, or preferred provider. In addition, an entity in developing practice profiles or otherwise measuring practitioner performance shall:
   a. Make severity adjustments, including allowances for the severity of illness or condition of the patient mix and allowances for patients with multiple illnesses or conditions;
   b. Periodically evaluate, with input from specialty-specific practitioners as appropriate, the quality and accuracy of practice profiles, data sources, and methodologies;
   c. Develop and implement safeguards to protect against the unauthorized use or disclosure of practice profiles; and
   d. Provide the opportunity for any practitioner at any time to examine the accuracy, completeness, or validity of any practice profile concerning the practitioner and to prepare a written response to the profile. The entity shall negotiate in good faith with the practitioner to correct any inaccuracies or to make the profile complete. If the inaccuracies or deficiencies are not corrected to the satisfaction of the practitioner, the entity shall submit the written response prepared by the practitioner along with the profile at the time the profile is used pursuant to subsection 1 or provided to any third party consistent with section 26.1-36-12.4.
3. This section does not limit the authority of the commissioner to obtain from an insurer information relating to an investigation of suspected or actual fraudulent insurance acts.

26.1-36-42. Grievance procedures.

1. An accident and health insurance policy may not be delivered or issued for delivery by an insurance company, as defined in section 26.1-02-01, or any other entity providing a plan of health insurance subject to state insurance regulation to a person in this state unless the entity establishes and maintains a grievance procedure for resolving complaints by covered persons and providers and addressing questions and concerns regarding any aspect of the plan, including access to and availability of services, quality of care, choice and accessibility of providers, and network adequacy. The

procedure must include a system to record and document all grievances since the date of its last examination of the grievances.

2. The procedure must be approved by the insurance commissioner. The commissioner may examine the grievance procedures.

26.1-36-43. Uniform prescription drug information card.

1. An insurance company, a nonprofit health service corporation, or a health maintenance organization that provides coverage for prescription drugs and that issues a card or other technology for prescription drug claims processing and an administrator of such coverage, including a third-party administrator for a self-insurance plan, a pharmacy benefits manager, and a state-administered plan may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the insured is also issued a uniform card or other technology containing uniform prescription drug information as provided under this section.
2. The uniform prescription drug information card or other technology must be in the format approved by the national council for prescription drug programs and must include all of the fields the issuer determines necessary to submit a claim and all the fields necessary to conform to the most recent pharmacy information card or technology implementation guide produced by the national council for prescription drug programs, or must include all the fields necessary to conform to a national format acceptable to the commissioner. All information the issuer determines necessary for claims submission of prescription drug benefits, exclusive of information provided on the prescription as required by law or rule, must be included on the card or other technology in a clear, readable, and understandable manner. All information on the card or other technology which is required under this section and which is not specified by the national council for prescription drug programs must be formatted and arranged in a manner that corresponds in content and format acceptable to the commissioner. All information on the card must be formatted and arranged in a manner that corresponds in content and format to the current content and format required by the issuer to process the claim. If an issuer requires a conditional or situation field as defined by the national council for prescription drug programs, the field must conform to the pharmacy information card or technology implementation guide produced by the national council for prescription drug programs or conform to the national format acceptable to the commissioner.
3. An issuer shall issue a new uniform prescription drug information card or other technology upon enrollment and reissue upon any change in the cardholder's coverage which impacts data in content or format as contained on the card or which affects the data content or format required to be on the card or other technology as required by this section. Newly issued cards or other technology must be updated with the latest coverage information and must conform to the national council for prescription drug programs standards and to the implementation guide or must conform to the format specified by the commissioner. However, the issuer may issue to the insured stickers or other methodologies to temporarily update cards as may be acceptable to the commissioner.
4. The card or other technology may be used for any health insurance coverage. This section does not require any person issuing the card or other technology to issue a separate card for prescription coverage, provided the card or other technology can accommodate the information necessary to process the claim as required by this section.

26.1-36-44. Independent external review.

This section applies to grandfathered health plans. "Grandfathered health plan" has the meaning stated in the Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152]. Every insurance company, nonprofit health service corporation, and health maintenance organization that offers

an accident and health line of insurance shall establish and implement an independent external review mechanism to review and determine whether medical care rendered under the line of insurance was medically necessary and appropriate to the claim as submitted by the provider. For purposes of this section, "independent external review" means a review conducted by the North Dakota health care review, inc., another peer review organization meeting the requirements of section 1152 of the Social Security Act, or any person designated by the commissioner to conduct an independent external review. A determination made by the independent external reviewer is binding on the parties. Costs associated with the independent external review are the responsibility of the nonprevailing party. A provider may not use an independent external review under this section unless the provider first has exhausted all internal appeal processes offered by the insurance company, nonprofit health service corporation, or health maintenance organization. The insurance commissioner shall take steps necessary to ensure compliance with this section. If federal laws or rules relating to independent external review are amended, repealed, or otherwise changed, the insurance commissioner shall adopt rules to ensure the independent external review procedure is in compliance with and substantively equivalent to the federal requirements.

26.1-36-45. Health insurance coverage not required.

1. Regardless of whether a resident of this state has or is eligible for health insurance coverage under a health insurance policy, health service contract, or evidence of coverage by or through an employer or under a plan sponsored by the state or federal government, the resident is not required to obtain or maintain a policy of individual health coverage except as may be required by a court or by the department of health and human services through a court or administrative proceeding.
2. This section does not render a resident of this state liable for any penalty, assessment, fee, or fine as a result of the resident's failure to procure or obtain health insurance coverage.
3. This section does not apply to:
   a. An individual who voluntarily applies for coverage under a state-administered program pursuant to the medical assistance program under title XIX of the federal Social Security Act [42 U.S.C. 1396 et seq.] or the state's children's health insurance program under title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
   b. A student who is required by an institution of higher education to obtain and maintain health insurance as a condition of enrollment.
   c. An individual who is required by a religious institution to obtain and maintain health insurance.
4. This section does not impair the rights of an individual to contract privately for health insurance coverage for family members or former family members.

26.1-36-46. External review procedures.

1. As used in this section, unless the context otherwise requires:
   a. "Adverse benefit determination" means a denial of, reduction of, termination of, or a failure to provide or make payment for a claim for benefits which involves medical judgment and involves the cancellation or discontinuation of coverage that has retroactive effect. The term includes a determination based on the requirements of an insurance company, nonprofit health services corporation, or health maintenance organization for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit and a determination that a treatment is experimental or investigational. The term does not include a denial of, reduction of, termination of, or failure to provide or make payment related to a claimant's eligibility for benefits under the terms of coverage.
   b. "Claim for benefits" means a request for one or more benefits which is made by a claimant in accordance with the reasonable procedure for submitting benefit claims offered by an insurance company, nonprofit health services corporation, or

health maintenance organization. A reasonable procedure includes an external review procedure that complies with this section.

c. "Claimant" means an individual who makes a claim for benefits under this section.

d. "Expedited external review" means an adverse benefit determination that involves:

(1) An admission, availability of care, a continued stay, or a health care service for which the claimant received emergency services but has not been discharged from the facility; or

(2) A medical condition for which the standard external review timeframes would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function.

e. "External review" is a review of an adverse benefit determination conducted pursuant to this section.

f. "Final external review determination" means a determination by an independent review organization at the conclusion of an external review.

g. "Independent review organization" means an entity that conducts independent external reviews of adverse benefit determinations.

2. An insurance company, nonprofit health services corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage meets the minimum requirements of 42 U.S.C. 300gg-19 and complies with 29 U.S.C. 1133, 29 CFR 2560.503-1; 42 U.S.C. 300gg-19, 26 CFR 54.9815-2719T; 29 U.S.C. 1185d, 29 CFR 2590.715-2719; and 26 U.S.C. 9815, 45 CFR 147.136. The insurance commissioner shall adopt rules as necessary to ensure compliance with this section and the federal minimum consumer protection standards. If federal laws or rules relating to external review are amended, repealed, or otherwise changed, the insurance commissioner shall adopt rules that track such changes to the federal external review rules to ensure the external review procedure set forth in this section is substantively equivalent and parallel to the federal requirements. An external review procedure must meet the requirement set forth in this section.

3. An external review process offered by an insurance company, nonprofit health services corporation, or health maintenance organization pursuant to this section must include each of the following:

a. An external review must be available to a claimant for:

(1) An adverse benefit determination involving medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit;

(2) A determination that a treatment is experimental or investigational if it is ensured that adequate clinical and scientific protocols are taken into account as part of the external review for determinations involving experimental or investigative claims for benefits; and

(3) An adverse benefit determination involving the cancellation or discontinuation of coverage that has a retroactive effect. For purposes of this paragraph, an adverse benefit determination does not include a denial, a reduction, a termination, or a failure to provide or make payment related to a claimant's eligibility for benefits under the terms of coverage.

b. An effective written notice must be provided to each claimant of the claimant's rights related to external review of an adverse benefit determination.

c. The insurance company, nonprofit health services corporation, or health maintenance organization may require a claimant to exhaust the internal claims and appeals process; however, a claimant may not be required to exhaust all internal and external claims and appeals processes if the insurance company, nonprofit health services corporation, or health maintenance organization waives this requirement, the claimant is considered to have exhausted the internal claims

and appeals process under applicable law, or the claimant has filed for expedited external review. A claimant may file for an expedited external review without fully exhausting all internal claims and appeals requirements at the same time any internal appeal is being processed and the claimant meets the defined criteria for requesting an expedited external review.

d. The insurance company, nonprofit health services corporation, or health maintenance organization against which a request for external review is submitted shall pay the cost of the independent review organization for completing the external review. An insurance company, nonprofit health services corporation, or health maintenance organization may require the claimant to pay a nominal filing fee from the claimant requesting an external review under this section. This fee may not exceed twenty-five dollars and must be refunded to the claimant if the adverse benefit determination is reversed by the independent review organization. A fee must be waived if payment imposes an undue hardship on the claimant. The fees charged by an insurance company, nonprofit health services corporation, or health maintenance organization to a claimant in any single plan year may not exceed seventy-five dollars.

e. A minimum dollar requirement may not be imposed for a claim for benefits to qualify for external review.

f. A claimant must have up to four months after receipt of notice of an adverse benefit determination to request external review.

g. A requirement that the commissioner assign external review to independent review organizations on a random basis or other method of assignment that assures the independence and impartiality of the assignment process, such as rotational assignment. The commissioner's process must provide for the maintenance of a list of at least three independent review organizations that are accredited by a nationally recognized private accrediting organization and are qualified to conduct the external review based on the nature of the health care service that is the subject of the review.

The commissioner may not use an independent review organization that has a conflict of interest that influences its independence. The independent review organization may not own or control, or be owned or controlled by, an insurance company, a nonprofit health services corporation, a health maintenance organization, a group health plan, the sponsor of a group health plan, a trade association of plans or insurance companies, or a trade association of health care providers. The independent review organization and clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the insurance company, nonprofit health services corporation, or health maintenance organization or plan that is the subject of the external review; with the claimant whose treatment is the subject of the external review; with any officer, director, or management employee of the insurance company, nonprofit health services corporation, or health maintenance organization; with employees, administrator, or sponsor of the claimant's health plan; with the health care provider or with the health care provider's group or practice association recommending the treatment that is subject to the external review; with the facility at which the recommended treatment would be provided; or with the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended and that is the subject of the external review.

h. The claimant must be notified that the claimant is allowed up to five business days to submit additional written information to the independent review organization and that this information must be considered by the independent review organization when completing the external review. Any additional information submitted by a claimant to an independent review organization for consideration in any external review must also be forwarded to the insurance company, nonprofit health services corporation, or health maintenance

organization within one business day of receipt by the independent review organization.

i. Any decision by an independent review organization through the external review process is binding on the claimant and on the insurance company, nonprofit health services corporation, or health maintenance organization, except to the extent other remedies are available under state or federal law and except that the requirement that the determination be binding does not preclude the insurance company, nonprofit health services corporation, or health maintenance organization from making payment on the claim for benefits or from failing to require such payment or benefits. The insurance company, nonprofit health services corporation, or health maintenance organization shall provide benefits, including making payment, pursuant to the final external review decision without delay, regardless of whether the insurance company, nonprofit health services corporation, or health maintenance organization intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

j. Within forty-five days of the independent review organization's receipt of the request for external review, the independent review organization shall provide written notice to the commissioner, the claimant, and the insurance company, nonprofit health services corporation, or health maintenance organization of the independent review organization's decision to uphold or reverse the adverse benefit determination. In regard to a request for an expedited external review, within seventy-two hours of the independent review organization's receipt of a request for expedited review, the independent review organization shall make a decision to uphold or reverse the adverse benefit determination and notify the commissioner, the claimant, and the insurance company, nonprofit health services corporation, or health maintenance organization of the determination. If the notice by the independent review organization is not in writing, the independent review organization shall provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

k. An insurance company, nonprofit health services corporation, or health maintenance organization shall include a description of the external review process in or attached to the policy, certificate of coverage, or other plan documents or evidence of coverage provided to covered individuals.

l. The contract with an independent review organization to provide external review services must require the independent review organization to maintain written records and to make those records specifically involving an external review available to the commissioner.

4. An insurance company, nonprofit health services corporation, or health maintenance organization provides an effective and relevant notice in a culturally and linguistically appropriate manner with respect to any applicable non-English language if the insurance company, nonprofit health services corporation, or health maintenance organization provides, upon request, a notice in any applicable non-English language and a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the insurance company, nonprofit health services corporation, or health maintenance organization. With respect to an address in any United States county to which such notice is sent, an applicable non-English language means that at least ten percent of the population residing in the county is literate only in the same non-English language as determined in guidance issued under federal law.

26.1-36-47. Internal claims and appeals procedures.

An insurance company, nonprofit health services corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage meets the minimum

requirements of 42 U.S.C. 300gg-19 and complies with 29 U.S.C. 1133, 29 CFR 2560.503-1; 42 U.S.C. 300gg-19, 26 CFR 54.9815-2719T; 29 U.S.C. 1185d, 29 CFR 2590.715-2719; and 26 U.S.C. 9815, 45 CFR 147.136. The insurance commissioner may take steps necessary to ensure compliance with this section. If federal laws or rules relating to internal claims and appeals are amended, repealed, or otherwise changed, the insurance commissioner shall adopt rules to ensure the internal claims and appeals procedure is in compliance with and substantively equivalent to the federal requirements.

26.1-36-48. Short-term care insurance - Rules - Penalty.

1. "Short-term care" means any insurance policy, group certificate of insurance, or rider advertised, marketed, offered, or designed to provide coverage for less than twelve consecutive months for each covered period on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, adult day care, or personal care services provided in an insured's own home or a licensed facility setting other than an acute care unit of a hospital.
2. Any policy or rider advertised, marketed, or offered as short-term care insurance must comply with this section and all other applicable insurance laws to the extent the other laws do not conflict with this section.
3. The insurance commissioner:
   a. May adopt rules that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of short-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, incontestability, rescission, return of policy provisions, and definitions of terms.
   b. May adopt rules establishing loss ratio standards for short-term care insurance policies; provided, that a specific reference to short-term care insurance policies is contained in the rules.
   c. May adopt rules to promote premium adequacy; protect the policyholder in the event of substantial rate increases; and to establish minimum standards for correcting abusive marketing practices, replacement forms, insurance producer testing, penalties, and reporting practices for short-term care insurance.
4. In addition to any other penalties provided by the laws of this state, any insurer and any insurance producer found to have violated any requirement of this title relating to the regulation of short-term care insurance or the marketing of such insurance is subject to a fine of up to three times the amount of any commission paid for each policy involved in the violation or up to ten thousand dollars, whichever is greater.

26.1-36-49. Short-term limited-duration health insurance plans.

Repealed by S.L. 2021, ch. 239, § 4.

26.1-36-50. Dental insurance - Assignment.

An individual or group insurance policy covering dental services may not be issued or renewed unless the policy authorizes the insured or beneficiary to assign reimbursement for health or dental care services directly to the provider of services. Under this assignment, the insurer, if authorized by the insured or beneficiary, shall pay directly to the provider the amount of the claim under the same criteria and payment schedule as would have been reimbursed directly to the insured.