NORTH DAKOTA ADMINISTRATIVE CODE

Supplements 201 through 204

March 1996
April 1996
May 1996
June 1996

Prepared by the Legislative Council staff
for the
Administrative Rules Committee

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TITLE 4.5

Addiction Counseling Examiners, Board of

MARCH 1996

CHAPTER 4.5-02-01

4.5-02-01-01. Licensure application. An application for a license to practice addiction counseling must be made to the state board of addiction counseling examiners on forms approved by the board upon request. Each application for a license must be accompanied by each of the following:

1. The required fee.
2. An official transcript verifying academic requirements.
3. An official document verifying practicum completion.
4. ~~Documentation--verifying-completion-of-a-minimum-one-year-(two thousand-hours)-internship.~~
5. ~~.~~ Documentation verifying a passing score on the prescribed examinations.

History: Effective August 1, 1988; amended effective August 1, 1991; November 1, 1994; March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-04
Law Implemented: NDCC 43-45-04, 43-45-05.1

4.5-02-01-02. Licensure renewal. Licenses are renewable annually providing that each of the following conditions have been met:

1. Proof of completion of required continuing education units is submitted by December ~~thirty-first~~ first of the renewal year.

2. License is not in suspension or revocation.

3. Renewal application form is completed and submitted prior to December first of each year.

4. Renewal application fee is submitted.

If the application for renewal does not meet the above conditions within six months of the expiration date of the license, the board may revoke the license.

History: Effective August 1, 1988; amended effective August 1, 1991; November 1, 1994; March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-07
Law Implemented: NDCC 43-45-04, 43-45-07

4.5-02-01-03. Fees. The board has adopted the following fee payment schedule:

1. Initial license fee:	$150.00
2. Annual renewal of license fee:	$ ~~75.00~~ 100.00
3. Initial private practice fee:	$ 50.00
4. Private practice annual renewal fee:	$ 25.00

History: Effective August 1, 1988; amended effective August 1, 1991; March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-04
Law Implemented: NDCC 43-45-04, 43-45-07

4.5-02-01-04. Academic requirements. Academic requirements related to the licensing of addiction counselors must be completed at an accredited college or university. A bachelor's degree is required after January 1, 1992. The following academic courses are also required. One semester hour is equivalent to fifteen contact hours.

1. Psychopathology, the equivalent to a two-semester credit (thirty contact hours) course in abnormal psychology from the upper division level.

2. Theories of personality, the equivalent to a two-semester credit course from an upper division level.

3. Theories in practice of psychotherapy, the equivalent to a two-semester credit course from an upper division level.

4. Pharmacology, the equivalent to a two-semester credit course from an upper division level, focusing on the physiological and pathological effects of mood altering drugs.

5. Introduction to group counseling, the equivalent to a two-semester credit course from an upper division level.

6. Introduction to individual counseling, the equivalent to a two-semester credit course from an upper division level.

7. Advanced counseling, the equivalent to a two-semester credit course from an upper division level.

8. Dynamics of addiction, the equivalent to a two-semester credit course from an upper division level ~~including a minimum of six classroom hours related~~ to include HIV/AIDS education.

9. Professional ethics, the equivalent to a one-semester credit course with content including: legal issues, client welfare as primary concern, professional competence, supervision and development, financial issues, personal wellness, and relationships to other counselors and institutions.

10. Marriage and the family, the equivalent to a two-semester credit course from an upper division level.

11. Child psychology or development, the equivalent to a two-semester credit course from an upper division level.

12. Adolescent psychology or development, the equivalent to a two-semester credit course from an upper division level.

History: Effective August 1, 1988; amended effective August 1, 1991; November 1, 1994; March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-04
Law Implemented: NDCC 43-45-04, 43-45-05.1

4.5-02-01-06. Internship. ~~The internship is a minimum of a twelve-month (two thousand hours) of addiction counseling professional experience or employment under the supervision of an approved clinical supervisor in a licensed addiction treatment facility approved by the board for internship training. Completion of the internship is documented by an evaluation from the intern's supervisor or the clinical director of the program, or both. An individual may remain an intern for a maximum of two years before completion of all examinations is required. Upon a showing of good cause, the board may, by special provision, extend internship status for longer than two years before completion of all examinations is required.~~ The internship is the practice of addiction counseling under the supervision of a board-approved clinical supervisor. There is no specified minimum amount of time in internship status. An intern may become licensed when both oral and written examinations are passed and all application criteria are met. An individual may remain an intern for a maximum of

two years before completion of all examinations is required. Upon a showing of good cause, the board, by special provision, may extend internship status for longer than two years before completion of all examinations is required.

History: Effective August 1, 1988; amended effective August 1, 1991; November 1, 1994; March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-04
Law Implemented: NDCC 43-45-04, 43-45-05.1

4.5-02-01-08. Reciprocity. Out-of-state applicants who have completed training in addiction counseling in another state or in a work or training setting which has not been approved by the board of addiction counseling examiners must document equivalencies in all areas of training including academic coursework, clinical training, ~~work experience;~~ and written and oral examinations. A person need not reside in the state or be employed in the state to make application or be licensed in North Dakota.

Clinical professional applicants who have related clinical proficiencies must document equivalencies in all areas of training including the academic coursework; and clinical training; ~~and work experience~~ and must satisfactorily complete the written and oral examinations if required by the board.

History: Effective August 1, 1988; amended effective August 1, 1991; November 1, 1994; March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-04
Law Implemented: NDCC 43-45-04, 43-45-05.1

4.5-02-01-09. Approved training ~~program~~ consortium.

1. Each training ~~program or~~ consortium for addiction counseling training must be approved biennially by the board of addiction counseling examiners. The training ~~program or~~ consortium must provide at a minimum, an application which must include documentation of the academic and clinical training experiences; syllabuses of academic courses or other evidence of the academic quality of those courses; evidence of licensure of addiction treatment facilities; evidence of certification of academic institutions involved and clinical supervisors' credentials, trainee handbook and guidelines, institutional policies related to training, including grievance procedures available to trainees, and goals and objectives for each training site.

   An approved training ~~program--or~~ consortium must meet the following conditions:

   a. Practicum training experiences must occur in at least two separate licensed treatment facilities with a minimum of

three months in each facility unless specifically approved by the board. These licensed facilities must consist of at least one public provider of addiction treatment and may be at either an inpatient or outpatient treatment setting.

b. Each training consortium must document ~~that the program provides~~ the provision of fifty hours of direct supervision in each of the following: individual therapy, intake and assessment, group therapy, and family counseling.

c. Each ~~program~~ consortium may establish the length of the practicum with a nine-month minimum requirement.

d. Academic instructor and clinical training supervisors must be board approved to perform their teaching and clinical supervisory function.

2. a. Training ~~programs~~ consortiums must have one board-approved clinical supervisor for each individual in training. In order to receive approval as a clinical supervisor prior to July 1, 1996, the following qualifications and conditions must be met:

(1) Complete and submit the required application.

(2) Have two years' experience as a licensed addiction counselor.

(3) Be approved by the board of addiction counseling examiners.

b. After July 1, 1996, the following qualifications and conditions must be met to receive approval as a clinical supervisor:

(1) Complete and submit the required application.

(2) Must have three years (six thousand hours) of supervised experience as a licensed addiction counselor.

(3) Must have completed a minimum of twenty hours of continuing education units of clinical supervisory training.

(4) Must submit two letters of reference and recommendation, one from the current clinical supervisor and one from another board-approved clinical supervisor.

(5) Be approved by the board of addiction counseling examiners.

3. Academic instructors of training ~~programs~~ consortiums must have an appropriate academic degree and otherwise be qualified in the specific field of instruction, and be a member of a college or university academic staff in order to be approved. In addition, the academic instructors must submit with the training ~~program and~~ consortium application the following:

   a. A letter of introduction to the board which should include a resume of past work experience, education, and experience in the field of addiction is preferred.

   b. A syllabus for each core academic class taught.

4. Individualized training plans may be board approved when they are submitted by and under the auspices of an approved training ~~program or~~ consortium. Each plan must designate the board-approved clinical supervisors responsible for the training and also provide additional information as required by the board.

History: Effective August 1, 1988; amended effective August 1, 1991; November 1, 1994; March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-04
Law Implemented: NDCC 43-45-04, 43-45-05.1

4.5-02-01-10. Internship sites.

1. Facilities must apply biennially to the board for approval as an internship site by providing the following information:

   a. Completed application form.

   b. Names of approved clinical supervisors within the facility who are responsible for supervising interns.

   c. Plan of supervision. This plan must be approved by the board on an individual site basis.

   d. Evidence of licensure as an addiction treatment facility.

2. An individualized internship plan may be approved when it is submitted by and under the auspices of an approved internship site. Each intern must have a board-approved clinical supervisor in a licensed facility and the internship site must provide additional information as required by the board.

3. All individuals working in the state as addiction counselors and who are not either licensed or in an approved training

~~program--or~~ consortium as an addiction counselor trainee must be in or supervised by an approved internship site.

History: Effective August 1, 1988; amended effective August 1, 1991; November 1, 1994; March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-04
Law Implemented: NDCC 43-45-04, 43-45-05.1

4.5-02-01-13. Internship status approval. Any individual practicing in the state as an addiction counselor intern must register with the board for internship status approval.

Internship status will be granted under the following conditions:

1. The individual has completed all required core academic coursework. With board approval, up to two courses may be taken while on internship status.

2. Has proof of completion of board-approved training ~~program~~ experience or has submitted out-of-state training experience with board-approved acceptance of equivalency.

3. Acceptance or proof of status in a board-approved internship site, or board-approved acceptance of individualized internship plan.

4. Completion of internship registration with required documentation.

History: Effective November 1, 1994; amended effective March 1, 1996.
General Authority: NDCC 28-32-02.1, 43-45-04
Law Implemented: NDCC 43-45-04, 43-45-05.1

CHAPTER 4.5-02-02

4.5-02-02-01. Code of professional conduct. The board has adopted and incorporated into this title a code of professional conduct for addiction counselors. The following constitutes unacceptable professional conduct for an addiction counselor and shall subject the counselor, training consortium, training program, or internship site, or any combination thereof, to sanction.

1. Exploiting relationships with clients such as participating in or soliciting sexual relationships during the time of services and for twelve months following the termination of services.

2. Taking financial advantage of client, or using one's position within an agency to enhance one's private practice or the private practice of others for personal gain.

3. Entering into any illegal acts with a client.

4. Participating in, condoning, or being an accessory to dishonesty, fraud, deceit, or misrepresentation in the practice of addiction counseling.

5. Not providing clients with accurate and complete information regarding the extent and nature of the services available to them.

6. Convicted of a criminal act which affects the practice of the profession. (North Dakota Century Code section 12.1-33-02.1)

7. Violating the federal or state confidentiality client care regulation statutes.

8. Violating the federal or state discrimination statutes or regulations.

9. Refusal to seek and follow through with adequate and appropriate treatment for any illness or disorder which interferes with professional functioning or ability to perform the basic expected functions, or both, of an addiction counselor.

10. Using misrepresentation in the procurement of licensing as an addiction counselor or knowingly assisting another in the procurement of licensing through misrepresentation: ~~Misrepresentation~~ of professional qualifications, certifications, accreditations, affiliation, and employment experiences.

11. Impaired behavior that adversely affects the licensee's ability to practice addiction counseling.

12. Any licensed addiction counselor or person subject to regulation by the board, having knowledge that another counselor or regulated person has violated the law or rules or whose knowledge of that counselor's incompetent, unethical, illegal, or impaired behavior raises a substantial question as to that counselor's fitness to be a member of the addiction counseling profession who fails to report that knowledge to the board.

13. Failure to act in a manner which meets the generally accepted standards of practice, including harassment of clients or coworkers, performing services outside individual's area of training, experience, or competence.

14. Failure to properly supervise trainees and interns practicing addiction counseling under the licensee's supervision in a board-approved training program or internship site.

15. Accepting as a client someone with whom the counselor already has another relationship which will or is likely to adversely affect the objectivity of the counselor. Examples include employee, supervisee, twelve-step sponsorship, or relative.

History: Effective August 1, 1988; amended effective August 1, 1991; November 1, 1994; March 1, 1996.
General Authority: NDCC 28-32-02.1
Law Implemented: NDCC 43-45-04, 43-45-07

TITLE 13

Banking and Financial Institutions, Department of

MAY 1996

CHAPTER 13-01.1-04

13-01.1-04-01. Notice. In those proceedings in which a hearing is to be held, the board ~~will, by order or otherwise,~~ shall assign a time and place for hearing, and issue notice ~~will be issued~~ of hearing. When the notice procedure is not specified by statute, notice ~~will~~ must be given at least twenty days prior to the date of the hearing, except in cases of emergency.

The notice procedures of the board are as follows, unless emergency circumstances require otherwise:

1. **Proposed rules.** Notice of proposed rules, inviting comments, will be given to all known interested parties by mail. Notice will also be published in the following newspapers:

   a. Bismarck Tribune, Bismarck.

   b. Devils Lake Daily Journal, Devils Lake.

   c. Dickinson Press, Dickinson.

   d. The Forum, Fargo.

   e. Grand Forks Herald, Grand Forks.

   f. Jamestown Sun, Jamestown.

   g. Minot Daily News, Minot.

   h. Williston Daily Herald, Williston.

i. Valley City Times-Record, Valley City.

j. The Daily News, Wahpeton.

2. **Bank applications.** Notice of hearing on an application for an organization certificate for a new bank ~~will~~ must be issued at least thirty days prior to the hearing on the application. Notice ~~will~~ must be mailed to all banks within the same service area as the location of the proposed new bank and published three times in the official ~~newspapers~~ newspaper of the county and city where the proposed bank is to be located.

3. ~~Paying--and-receiving-station-applications.--Notice-of-hearing on-an-application-to-establish-a-paying-and-receiving--station will--be--issued-in-the-same-manner-and-to-the-same-parties-as specified-in-subsection-2.~~

4.~~--Separate----facility~~ Facility **applications.** Notice of application for a ~~separate-drive-in-and-walk-up~~ facility ~~will~~ must be issued as specified in sections 13-02-05-05 and 13-02-05-08.

5. 4. **Electronic funds transfer center applications.** Notice of intent to apply for authorization to establish an electronic funds transfer center ~~shall~~ must be issued as specified in section 13-02-06-12.

6. 5. **Move of bank to new location.** Notice of hearing on an application to move a bank to some place within the state other than the town in which it is presently located ~~will~~ must be issued in the same manner ~~and--to--the--same--parties~~ as specified in subsection 2.

7. 6. **Savings and loan branch applications.** Notice of hearing on an application for a savings and loan branch ~~will~~ must be issued at least thirty days prior to the hearing on the application, and ~~will~~ must be published three times in the official ~~newspapers~~ newspaper of the county and city in which the proposed branch is to be located.

~~The--board-may-mail-a-copy-of-the-notice-to-the-chairperson-of-the board-of-county-commissioners-in-each-county-wherein-citizens-who-are-or will-be-affected-reside,-and-to-the-chief-executive-officer-of-each-city affected-in-the-county.~~

~~In--addition,-the-board-may,-in-those-instances-where-it-regularly issues-notice-to-the-official-newspaper-of-the-county--to--be--affected, also--issue--the-same-notice-to-the-official-newspapers-of-the-adjoining counties,-if-those-areas-would-similarly-be-affected.~~

The board may also give additional notice where it deems such action appropriate.

The procedures outlined above may be ~~altered~~ modified by the commissioner or board in cases of an emergency.

History: Effective January 1, 1980; amended effective May 1, 1993; November 1, 1994; May 1, 1996.
General Authority: NDCC 6-01-04, 28-32-02
Law Implemented: NDCC 6-01-01, 6-01-04, 6-02-05, 6-03-02(8), 6-03-13, 6-03-13.3, 6-03-16, 6-05-01, 7-01-01, 28-32-02

13-01.1-04-02. Appearances. Interested parties shall enter their appearances at the beginning of the hearing by giving their name and address and briefly ~~stating~~ state whether they appear in support of or in opposition to the complaint or application~~,-in-opposition-thereto,-or otherwise~~. All ~~such~~ appearances ~~shall~~ must be noted on the record with a notation in whose behalf each appearance is made. ~~Included--in--such appearances--shall--be-the~~ The names of the members of the board's staff participating in the hearing or investigation must also be noted.

History: Effective January 1, 1980; amended effective May 1, 1996.
General Authority: NDCC 6-01-04, 28-32-02
Law Implemented: NDCC 6-01-01, 6-01-04, 28-32-11.1

13-01.1-04-06. Order of procedure. In hearings on formal complaints, petitions, and applications, the complainant, petitioner, or applicant~~,--as-the-case-may-be,-shall~~ must open and close. In all other hearings, the hearing officer may direct who shall open and close. ~~Intervenors-shall-follow-the-parties-in-whose-behalf-the-intervention-is made;-where-the-intervention-is-not-in-support-of-an-original-party,-the~~ The hearing officer shall designate at which stage ~~such~~ an intervenor shall be heard.

History: Effective January 1, 1980; amended effective November 1, 1994; May 1, 1996.
General Authority: NDCC 6-01-04, 28-32-02
Law Implemented: NDCC 6-01-01, 6-01-04, 28-32-11.1

CHAPTER 13-02-05

13-02-05-01. Application to banking board required. Whenever any state bank desires to maintain and operate a facility separate ~~and~~-apart from its banking house, or to move a facility previously established to another location, it ~~shall~~ must apply to the state banking board for such authority. ~~The--application--shall--be-governed-by-the-procedure specified-in-this-chapter.~~

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.1

13-02-05-02. Delivery of copies to board. An original and six copies of the application ~~shall~~ must be delivered to the state banking board.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.1

13-02-05-03. Contents of application. The application ~~shall~~ must contain the following information:

1. A copy of the applicant bank's most recent daily financial statement.

2. ~~Copies~~ A copy of the applicant bank's yearend financial statements for the last two preceding years.

3. The names and addresses of all other banks within the ~~corporate-city-limits-of-the--applicant--bank's--main--banking house--or--within--three-miles-of-such-city-but-not-within-the corporate--limits--of--another--city,--and--the--addresses--of separate--facilities-maintained-by-such-other-banks~~ trade area of the banking institution's proposed facility.

4. A description of the site of the proposed separate facility.

5. A description of the proposed separate facility, and an estimate of the cost of establishing and maintaining ~~such~~ separate the facility.

6. A statement relating to the convenience, needs, and welfare of the people of the community and area to be served by the proposed separate facility.

7. A statement relating to whether ~~or not~~ other banks will be seriously injured by the approval of the application.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.3

13-02-05-04. Availability for inspection. The application ~~shall~~ must be available for inspection in the office of the commissioner of banking and financial institutions.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.3

13-02-05-05. ~~Notice--of--application-required~~ Publication. Upon ~~receipt-of-an-application-to-establish-a-separate--facility,--the--state banking--board-will-provide-notice-of-the-application-to-all-other-banks located-within-the-corporate-city-limits-of-the-main--banking--house--of the--applicant--bank--and-within-three-miles-of-such-city-but-not-within the-corporate-limits-of-another-city~~ filing a completed application, the secretary of the board shall cause to be published notice of application once a week for two successive weeks in the official newspaper of the county where the proposed facility is to be located. The notice of application must also be sent by certified mail by the secretary of the board to all banks and bank facilities, if not sent to the main office, located within the trade area of the banking institution's proposed facility. Within fifteen days of the final notice provided under this section, any bank or person may submit to the board written comments concerning the application or a written request for an opportunity to be heard before the board, or both.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04, 6-03-11
Law Implemented: NDCC 6-03-11, 6-03-13.3

13-02-05-06. Timely submission of written comments - Written request for a hearing - Board's authority to hold hearing. Within ~~ten~~ fifteen days ~~after--receipt~~ of the final notice provided pursuant to section 13-02-05-05, any ~~of-such-other-banks~~ bank or person may submit to the board written comments concerning the application or a written request for an opportunity to be heard before the board, or both. In the absence of a request, the board may, when it believes it to be in the public interest, order a hearing to be held.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.3

13-02-05-07. Setting of date, time, and place for hearing. If a written request for an opportunity to be heard before the board is submitted to the board or if the board, on its own initiative, orders that a hearing be held, the board ~~will~~ shall set a date, time, and place for the hearing.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.3

13-02-05-08. Procedure to afford notice of hearing. If a hearing on the application is to be held, the board ~~will~~ must issue a ~~notice--of application,~~ notice of hearing, and specification of issues, ~~and notice of opportunity to be heard to the applicant,~~ to any bank or person which requested in writing that a hearing be held, and to any bank which has submitted written comments concerning the application. The board ~~will~~ must also publish ~~such notice of application,~~ the notice of hearing, and specification of issues, ~~and notice of opportunity to be heard~~ one time in a newspaper of general circulation in the community where the facility is to be located.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.3

13-02-05-09. Applicant to furnish court reporter and transcript. The applicant shall arrange to have a court reporter or stenographer present at any hearing on an application to establish a separate facility ~~and shall furnish to the board a transcript of the evidence taken before the board~~ unless approval is provided by the board to arrange for the use of an electronic recording device as a substitute for having a court reporter or stenographer present. Upon request, the applicant shall furnish each member of the board a transcript of the evidence taken before the board.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.3

13-02-05-11. Procedure on application if no hearing. If no request for a hearing upon an application to establish a separate facility is submitted to the board within the time period specified in section 13-02-05-06, and the board has not, on its own initiative, ordered that a hearing be held, the board ~~will~~ shall approve or deny the application by order upon consideration and motion at a regular or special meeting of the board.

History: Amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC 6-03-13.3

CHAPTER 13-02-18

13-02-18-01. Publication. Upon filing a completed application, the bank shall cause to be published notice of application once a week for two successive weeks in the official newspaper of the county where the ~~paying-and-receiving-station~~ facility is located. The notice must invite comments be sent to the board. Any ~~party~~ person must submit written comments concerning the application to the board no later than thirty days after the date of final publication. The notice may be included with any notice for a branch closing required by the federal deposit insurance corporation or the federal reserve board.

History: Effective June 1, 1994; amended effective May 1, 1996.
General Authority: NDCC 6-01-04
Law Implemented: NDCC ~~6-03-19~~ 6-03-13.1

TITLE 20

Dental Examiners, Board of

MAY 1996

CHAPTER 20-01-02

20-01-02-01. Definitions. Unless specifically stated otherwise, the following definitions are applicable throughout this title:

1. "Basic full upper and lower denture" means replacement of all natural dentition with artificial teeth. This replacement includes satisfactory tissue adaptation, satisfactory function, and satisfactory aesthetics. Materials used in these replacements must be nonirritating in character and meet all the standards set by the national institute of health and the bureau of standards and testing agencies of the American dental association for materials to be used in or in contact with the human body.

2. "Board certified" means the dentist has been certified in a specialty area where there is a certifying body approved by the commission on dental accreditation of the American dental association.

3. "Board eligible" means the dentist has successfully completed a duly accredited training program or in the case of a dentist in practice at the time of the adoption of these rules has experience equivalent to such a training program in an area of dental practice where there is a certifying body approved by the commission on dental accreditation of the American dental association.

4. "Certified dental assistant" means a dental assistant who has satisfactorily completed the educational requirements specified by the commission on dental accreditation of the American dental association for dental assistants or has two

years of full-time work experience, and who has passed the dental assisting national board certification examination for dental assistants.

2. 5. "Complete evaluation" means an examination, review of medical and dental history, the formulation of a diagnosis, and the establishment of a written treatment plan, documented in a written record to be maintained in the dentist's office or other treatment facility or institution.

3. 6. "Conscious sedation" means a drug-induced state in which the patient is calmed and relaxed, capable of making rational responses to commands and has all protective reflexes intact, including the ability to clear and maintain his own airway in a patent state, but does not include nitrous oxide sedation.

4. 7. "Coronal polishing" is the mechanical polishing of clinical crowns using a rubber cup or brush only and not to include any instrumentation. Examination for calculus and instrumentation must be done by the dentist or hygienist.

5. 8. "Dental assistant" means a person who under the direct supervision of a dentist renders assistance to a dentist or dental hygienist as described in article 20-03.

6. 9. "Dental hygienist" means any person who is a graduate of a school of dental hygiene with a minimum of two academic years of dental hygiene curriculum approved or provisionally approved by the commission on dental accreditation of the American dental association and who is registered and licensed by the North Dakota state board of dental examiners.

7. 10. "Dental technician" means any individual who offers or undertakes to perform the fabrication or repair of corrective or prosthetic dental devices according to the written instructions of a licensed dentist. A certified dental technician is an individual who is specifically qualified through education and experience and who has successfully completed the written and practical certification examinations administered by the national board for certification, and who further maintains certification through compliance with continuing education requirements as stipulated by the national board for certification.

8. 11. "Direct supervision" means the dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the dental hygienist or dental assistant, and before dismissal of the patient, evaluates the performance of the dental hygienist or dental assistant.

~~9.~~ 12. "Evaluation" means the act or process by a dentist of assessing and determining the significance, quality or work of something such as the patient's oral health status, the progress of dental therapy, or the performance of the dental hygienist or dental assistant.

~~10.~~ 13. "General anesthesia" means a controlled state of unconciousness produced by pharmacologic or nonpharmacologic methods, or a combination thereof, accompanied by a partial or complete loss of protective reflexes including an inability to independently maintain an airway and to respond purposefully to physical stimulation or verbal commands.

~~11.~~ 14. "General supervision" means the dentist has authorized the procedures and they are carried out in accordance with the dentist's diagnosis and treatment plan. The dentist is not required to be in the treatment facility. Limitations are contained in North Dakota Century Code section 43-20-03.

~~12.~~ 15. "Indirect supervision" means that a dentist is in the dental office or treatment facility, has personally diagnosed the condition to be treated, authorizes the procedures, and remains in the dental office or treatment facility while the procedures are being performed by the dental hygienist or dental assistant.

~~13.~~ 16. "Modified general supervision" means that the dentist must personally evaluate the patient, diagnose the conditions to be treated, and plan and authorize treatment. The dentist must personally evaluate the patient at each visit, but need not be present when treatment is initiated or remain until procedures are completed on a patient of record who has been seen in the office in the previous twelve months.

17. "Oral hygiene treatment planning" means the process of assessing and determining, by the dentist and the hygienist, the services the dental hygienist will perform, including preventative, educational, and instrumentation. This treatment plan is an organized sequence of events that is a part of the dentist's total treatment plan. The total treatment plan and diagnosis are to be determined by the dentist.

~~14.~~ 18. "Patient of record" means a patient who has undergone a complete dental evaluation performed by a licensed dentist.

~~15.~~ 19. "Personal supervision" means a level of supervision indicating that the dentist or dental hygienist is personally treating a patient and authorizes the dental hygienist or dental assistant to aid the treatment by concurrently performing a supportive procedure.

20. "Primary practice site" means the office location that is to be considered the main location of the dental practice. This office location would be listed first on the annual registration.

~~16.~~ 21. "Registered dental assistant" means a dental assistant who is a graduate of a dental assistant program approved or provisionally approved by the commission on dental accreditation of the American dental association, or who has completed two years of full-time work experience as a dental assistant and has completed dental assistant national boards, or who has completed a course in dental assisting which is approved by the North Dakota board of dental examiners, and who is registered by the North Dakota state board of dental examiners.

~~17.~~ 22. "Satellite office" means an office, building, or location used at any time by a dentist for the practice of dentistry other than the office listed on his annual registration certificate.

History: Effective September 1, 1980; amended effective February 1, 1992; October 1, 1993; May 1, 1996.
General Authority: NDCC 43-28-06
Law Implemented: NDCC 43-20-02, 43-20-12, 43-28-06

CHAPTER 20-02-01

20-02-01-02. Office emergency. Every dentist ~~or~~, dental hygienist, or registered dental assistant practicing in North Dakota must have a current certificate of proficiency in cardiopulmonary resuscitation.

History: Effective February 1, 1992; amended effective October 1, 1993; May 1, 1996.
General Authority: NDCC 43-28-06
Law Implemented: NDCC 43-28-06

20-02-01-03. Nitrous oxide. A duly licensed dentist may use nitrous oxide for treating patients only when the following conditions are met:

1. Documentation has been provided by the dentist to the board that verifies completion of sixteen hours of instruction or continuing professional education dealing specifically with the use of nitrous oxide. In the absence of documentation of classroom training, the dentist must provide proof acceptable to the board that demonstrates three years of practical experience in the use of nitrous oxide.

2. A dentist who induces a patient into a state of psychosedation or relative analgesia using nitrous oxide shall ensure that the patient will be continually and personally monitored by a dentist. A dentist may delegate the monitoring tasks to a licensed dental hygienist or a certified dental assistant utilizing direct supervision only after the patient has been stabilized at the desired level of conscious sedation or relative analgesia by the action of the dentist. The licensed dental hygienist or certified dental assistant who is assigned the monitoring task shall remain in the treatment room with the patient at all times. A dental hygienist or a dental assistant may not initiate the administration of nitrous oxide to a patient.

3. The dentist must provide and document training for the dental hygienist or certified dental assistant in the proper and safe operation of the analgesia machine being used, including the emergency procedures to be employed if required.

History: Effective February 1, 1992; amended effective May 1, 1996.
General Authority: NDCC 43-28-06
Law Implemented: NDCC 43-28-06

20-02-01-05. Permit for anesthesia use.

1. On and after October 1, 1993, a dentist licensed under North Dakota Century Code chapter 43-28 and practicing in North Dakota may not use general anesthesia or conscious sedation on any patient unless such dentist has a permit, currently in effect, issued by the board, initially for a period of twelve months and renewable annually thereafter, authorizing the use of such general anesthesia or conscious sedation.

2. An applicant may not be issued a permit initially as required in subsection 1 unless:

   a. The dental examiners approve the applicant's facility after an inspection conducted by ~~the dental examiners or~~ by an individual or individuals designated by the dental examiners;

   b. The dental examiners are satisfied that the applicant is in compliance with guidelines in the American dental association guidelines for teaching and comprehensive control of pain and anxiety in dentistry; and

   c. The initial application includes payment of a fee in the amount determined by the dental examiners.

3. The dental examiners may renew such permit annually, provided:

   a. Application for renewal is received by the dental examiners before the date of expiration of such permit;

   b. Payment of a renewal fee in the amount to be determined by the dental examiners is received with such application; and

   c. An onsite evaluation of the dentist's facility ~~is~~ may be conducted ~~by the dental examiners or~~ by an individual or individuals designated by the dental examiners, ~~provided such examination is conducted without cost to the state not less than once every five years after the initial evaluation of such facility~~ and the dental examiners must approve the results of each such evaluation.

History: Effective October 1, 1993; amended effective May 1, 1996.
General Authority: NDCC 43-28-06
Law Implemented: NDCC 43-28-06

20-02-01-06. Continuing dental education for dentists, dental hygienists, and dental assistants. Each dentist, dental hygienist, or dental assistant licensed or registered in this state shall provide evidence on forms supplied by the board that the person has attended or

participated in continuing dental education in accordance with the following conditions:

1. The continuing dental education hours will accumulate on the basis of one hour of credit for each hour spent in actual teaching sessions. Subject matter directly related to clinical dentistry will be accepted by the board without limit. Limits are established for nonclinical subjects.

2. The minimum number of hours required within a five-year cycle for dentists is eighty.

3. The minimum number of hours required within a five-year cycle for dental hygienists is forty.

4. The minimum number of hours for a registered dental assistant is eight hours annually.

5. Of these hours, a dentist may earn no more than fifteen hours, a dental hygienist may earn no more than eight hours, and a registered dental assistant may earn no more than four hours in nonclinical subjects relating to the dental profession.

6. Nonclinical subjects relating to the dental profession are those which cover skills relating to dental services in general which are not related to, but are nevertheless supportive of, the provision of clinical dental services. Examples of nonclinical subjects relating to the dental profession are patient management, the legal and ethical responsibilities of the dental profession, and stress management.

7. Examples of nonclinical subjects that will not be creditable to the continuing education requirement are those that deal with estate planning, financial planning, marketing, investments, and personal health.

8. Mere registration at a dental convention without specific attendance at continuing education presentations will not be creditable towards the continuing dental education requirement.

9. The infection control continuing education requirement for dentists, dental hygienists, and registered dental assistants <u>practicing in North Dakota</u> is two hours annually and is a requirement for renewal of the annual certificate of registration. This training may be accomplished in an office setting or at a sponsored course.

History: Effective October 1, 1993; <u>amended effective May 1, 1996</u>.
General Authority: NDCC 43-28-06
Law Implemented: NDCC 43-20-12.1, 43-28-06, 43-28-12.2

CHAPTER 20-03-01

20-03-01-01. Duties. A dental assistant may perform the services listed in subsections 1 through 6 under direct supervision of a licensed dentist. A dental assistant may perform the duties set forth in subsections 7 through 27 only if the dental assistant is a dental assisting national board certified dental assistant, the dental assistant has a certificate of successful completion of a course in dental assisting from a school recognized by the American dental association, or the dental assistant has successfully completed a course approved by the North Dakota board of dental examiners.

1. Take and record pulse, blood pressure, and temperature.
2. Take and record preliminary dental and medical history for the interpretation by the dentist.
3. Apply topical medications and drugs to oral tissues, including topical anesthetic, but not including desensitizing or caustic agents or anticariogenic agents.
4. Receive removable dental prosthesis for cleaning or repair.
5. Take impressions for study casts.
6. Hold impression trays in the mouth (e.g. reversible hydrocolloids, rubber base).
7. Take dental radiographs.
8. Remove sutures.
9. Apply anticariogenic agents topically.
10. Place and remove rubber dams.
11. Remove excess supragingival cement from coronal surfaces of teeth with hand instruments only.
12. Place and remove orthodontic wires or appliances that have been activated by the dentist.
13. Tie ligature wires or elastic ties.
14. Preselect and prefit orthodontic bands.
15. Fabricate, place, and remove a temporary crown or onlay. This applies only to a tooth or teeth actively under treatment for which a permanent restoration is being fabricated.

16. Monitor a patient who has been inducted by a dentist into nitrous-oxide relative analgesia.

17. Place and remove periodontal dressings.

18. Place orthodontic elastic-type separators.

19. Remove ligature wires or elastic ties, or both.

20. Remove arch wires.

21. Perform nonsurgical clinical and laboratory oral diagnosis tests for interpretation by the dentist.

22. Polish the coronal surfaces of the teeth with a rubber cup or brush only after necessary scaling by a hygienist or dentist.

23. Acid-etch enamel surfaces prior to pit and fissure sealants, direct bonding of orthodontic brackets, or composite restorations.

24. Take impressions for passive posttreatment orthodontic retainers which do not replace missing teeth. Dental assistants may take impressions for athletic mouth guards.

25. Apply desensitizing solutions to the external surfaces of the teeth.

26. Place and remove matrix bands.

27. Place retraction cord in the gingival sulcus of a prepared tooth prior to the dentist taking an impression of the teeth.

History: Effective September 1, 1980; amended effective February 1, 1992; October 1, 1993; May 1, 1996.
General Authority: NDCC 43-20-10
Law Implemented: NDCC 43-20-12

20-03-01-03. Annual registration of dental assistants performing expanded duties.

1. Any individual engaged in performing expanded duties in the practice of dental assisting in the state of North Dakota (those duties set out in subsections 7 through 27 of section 20-03-01-01) must register with the board of dental examiners by submitting an application accompanied by a fee determined by the board. Thereafter, on a yearly basis, before expiration, every dental assistant performing expanded duties shall transmit to the board a registration fee determined by the board and evidence of completion of continuing education requirements, together with other pertinent information as required. At least thirty days before the certificate of

registration expiration date, the ~~administrative--secretary~~ executive director of the board shall send to every dental assistant performing expanded duties a written notice stating the amount and due date of the fee. A late fee determined by the board shall be assessed if the registration renewal application and fee are not received by the board before expiration.

2. A certificate of registration will be issued by the board to a dental assistant when:

   a. The dental assistant has applied to the board and paid the registration fee determined by the board, and;

   b. The dental assistant possesses one of the following professional qualifications:

      (1) The dental assistant is currently dental assistant certified by dental assisting national board;

      (2) The dental assistant has completed a course in dental assisting from a school of dental assisting accredited by the commission on dental accreditation of the American dental association; or

      (3) The dental assistant has completed a course in dental assisting which is approved by the North Dakota board of dental examiners.

3. Every registered dental assistant performing expanded duties shall provide the board a current business mailing address. A registered dental assistant may not practice in this state for more than thirty days after a change of business address without providing the board with written notice of the new address by first-class mail.

4. Each year registered dental assistants performing expanded duties shall submit to the board with the annual registration evidence of attendance or participation in continuing dental education acceptable to the board. To remain in good standing, a registered dental assistant performing expanded duties must complete at least eight hours of continuing education each year. The board shall suspend the registration of any person who fails to comply with this section.

5. A dental assistant who is not registered may, at the direction of a licensed dentist, perform only basic dental assisting services listed in subsections 1 through 6 of section 20-03-01-01.

6. The provisions requiring registration contained in this section do not apply to dental assistants who are employed on a part-time basis and who are qualified as required by section

20-03-01-03. Part-time employment is defined as working less than twenty-six hours per week or a period of employment of less than ninety days.

7. Current certification in cardiopulmonary resuscitation shall be required for registration.

History: Effective October 1, 1993; amended effective May 1, 1996.
General Authority: NDCC 43-28-06
Law Implemented: NDCC 43-28-06

CHAPTER 20-04-01

20-04-01-01. Duties. A dental hygienist may perform the following services under the general, direct, indirect, or modified general supervision of a dentist.

1. Complete prophylaxis to include removal of accumulated matter, deposits, accretions, or stains from the natural and restored surfaces of exposed teeth. The dental hygienist may also do root planing and soft tissue curettage upon direct order of the dentist.

2. Polish and smooth existing restorations.

3. Apply topical applications of drugs to the surface tissues of the mouth and to exposed surfaces of the teeth.

4. Take impressions for study casts.

5. Take and record preliminary medical and dental histories for the interpretation by the dentist.

6. Take and record pulse, blood pressure, and temperature.

7. Take dental radiographs.

8. Hold impression trays in the mouth after placement by a dentist (e.g. reversible hydrocolloids, rubber base, etc.).

9. Receive removable dental prosthesis for cleaning and repair.

10. Remove sutures.

11. Apply anticariogenic agents topically.

12. Place and remove rubber dams.

13. Place and remove orthodontic wires or appliances, or both, that have been activated by the dentist.

14. Tie ligature wires or elastic ties, or both.

15. Preselect and prefit orthodontic bands.

16. Monitor a patient who has been inducted by a dentist into nitrous-oxide relative analgesia.

17. Fabricate, place, and remove a temporary crown or onlay. This applies only to a tooth or teeth actively under treatment for which a permanent restoration is being fabricated.

18. Place and remove periodontal dressings.

19. Place orthodontic elastic-type separators.

20. Remove ligature wires or elastic ties, or both.

21. Remove arch wires.

22. Perform nonsurgical clinical and laboratory oral diagnostic tests for interpretation by the dentist.

23. Acid-etch enamel surfaces prior to pit and fissure sealants, direct bonding of orthodontic brackets, or composite restorations.

24. Apply etching solutions to teeth and etch enamel and place pit and fissure sealants. ~~When a dentist delegates this task to a dental hygienist, the application of the sealant must, without exception, be done as a four-handed procedure - from the time the etchant is placed on the tooth until the sealant is cured.~~

25. A dentist or program manager, supervising federal-sponsored or state-sponsored public health dental hygiene programs, may petition the state board of dental examiners for a specific exemption to the requirement for four-handed application of pit and fissure sealants by dental hygienists.

26. ~~A dental hygienist may practice under general supervision in a federal or state dental public health setting - when a supervisory dentist has examined the patient and has evaluated the patient's dental health plan and has issued to a licensed dental hygienist specific written orders for the prescribed treatment. - The dentist or program manager operating federal-sponsored or state-sponsored dental public health clinics shall obtain from the state board of dental examiners the specific written authority to utilize general supervision of dental hygienists.~~

~~27.~~ Take impressions for passivepost treatment orthodontic retainers which do not replace missing teeth. Dental hygienists may take impressions for athletic mouth guards.

~~28.~~ 27. Apply desensitizing solutions to the external surfaces of the teeth.

~~29.~~ 28. Place and remove matrix bands.

29. Provide oral hygiene treatment planning.

History: Effective September 1, 1980; amended effective February 1, 1992; October 1, 1993; May 1, 1996.
General Authority: NDCC 43-20-10
Law Implemented: NDCC 43-20-03

CHAPTER 20-05-01

20-05-01-01. Fees. The following fees apply to the services listed:

1. The nonrefundable fee to process an application for a license to practice for an applicant who has completed a clinical board examination within the time period allowed by the state board of dental examiners is two hundred dollars for a dentist and fifty-five dollars for a dental hygienist.

2. The nonrefundable fee to process an application for a license by a review of the applicant's professional credentials without additional clinical examination is four hundred fifty dollars for a dentist and one hundred sixty-five dollars for a dental hygienist.

3. The nonrefundable fee to process an application for a temporary license to practice dentistry is ~~four~~ one hundred ~~fifty~~ sixty dollars.

4. The certificate of registration annual renewal fee is ninety dollars for a dentist and forty-five dollars for a dental hygienist.

5. The penalty for late renewal of annual certificate of registration is ~~one-hundred~~ fifty dollars for dentists and dental hygienists and dental assistants in addition to the fee specified above for renewal.

6. The fee to replace or provide a duplicate copy of a dental or dental hygiene license is twenty-five dollars.

7. The fee to reactivate a retired dental or dental hygiene license is the sum of each year's annual renewal fee since the license was retired plus one hundred dollars. Maximum number of years will be five (maximum fee five hundred fifty dollars for dentists; three hundred twenty-five dollars for hygienists).

8. The fee for annual registration for registered dental assistants is twenty-five dollars.

9. The nonrefundable fee to process an application by a Moorhead, Minnesota dentist for a restricted dental license to treat emergency dental patients at Dakota Hospital in Fargo, North Dakota, is one hundred dollars.

10. The annual registration fee for renewal of a restricted dental license to treat emergency dental patients at Dakota Hospital in Fargo, North Dakota, is fifty dollars.

11. The fee for an onsite facility inspection to obtain permit for anesthesia use ~~is two hundred dollars per hour for time spent by the inspector to inspect premises plus travel and per diem expense for inspection at the rate charged by~~ will be at a rate similar to compensation paid board members for services rendered to the state of North Dakota.

12. The fee for initial application and annual renewal of a permit to use general anesthesia or conscious sedation is ~~one hundred~~ fifty dollars.

History: Effective May 1, 1992; amended effective October 1, 1993; May 1, 1996.
General Authority: NDCC 43-28-06
Law Implemented: NDCC 43-28-27

TITLE 33

State Department of Health

MARCH 1996

STAFF COMMENT: Chapter 33-31-03 contains all new material and is not underscored so as to improve readability.

CHAPTER 33-31-03
SALVAGED FOOD

33-31-03-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Distressed food" means any food, the label of which has been lost, defaced, or obliterated; food that has been subjected to possible damage due to accident, fire, flood, adverse weather, or to any other similar cause; or food that is suspected of having been rendered unsafe or unsuitable for food use.

2. "Labeling" means any legal or descriptive matter or design appearing upon an article of food or its container, and includes circulars, pamphlets, and the like, which are packed

and go with the article to the purchaser, and placards that may be allowed to be used to describe the food.

3. "Reconditioned or salvaged food" is reconditionable or salvageable food that has been reconditioned or salvaged under supervision of the department.

4. "Reconditioning" or "salvaging" is the act of cleaning, culling, sorting, labeling, relabeling, or in any other way treating distressed food so that it may be deemed to be reconditioned or salvaged food and therefore is acceptable for sale or use as human food, animal feed, or seed as provided by the department.

5. "Salvage food distributor" means a person who engages in the business of selling, distributing, or otherwise trafficking at wholesale in any distressed or salvaged food.

6. "Salvaged processing facility" means an establishment engaged in the business of reconditioning or by any other means salvaging distressed food for human consumption or use.

History: Effective March 1, 1996.
General Authority: NDCC 23-01-03
Law Implemented: NDCC 23-09-24

33-31-03-02. Protection of salvageable and salvaged merchandise. All salvageable and salvaged merchandise, while being stored or reconditioned at a salvage processing facility or during transportation, must be protected from contamination. All salvageable merchandise must be properly sorted and segregated from nonsalvageable food to prevent further contamination of the food to be reconditioned for sale or distribution.

History: Effective March 1, 1996.
General Authority: NDCC 23-01-03
Law Implemented: NDCC 23-09-24

33-31-03-03. Reconditioning.

1. All metal cans of food offered for sale or distribution must be essentially free from rust or pitting and dents, especially at rim, end double seams, or side seams. Leakers, springers, flippers, and swells must be deemed unfit for sale or distribution. Containers, including metal and glass containers with press caps, screw caps, pull rings, or other types of openings which have been in contact with water, liquid foam, or other deleterious substances, as a result of firefighting efforts, flood, sewer backups, or similar mishaps, must be deemed unfit for sale or distribution.

2. All metal containers of food, other than those mentioned in subsection 1, whose integrity has not been compromised and whose integrity would not be compromised by the reconditioning, and which have been in contact with water, liquid foam, or other deleterious substance as a result of flood, sewer backup, or other reasons, after thorough cleaning, must be subjected to sanitizing rinse of a concentration of one hundred ppm available chlorine for a minimum period of one minute, or must be sanitized by another method approved by the department. They must subsequently be treated to inhibit rust formation.

History: Effective March 1, 1996.
General Authority: NDCC 23-01-03
Law Implemented: NDCC 23-09-24

33-31-03-04. Labeling requirements.

1. Any container of food with the label of mandatory information missing which cannot be identified and relabeled correctly may not be sold. When original labels are missing or illegible, relabeling or overlabeling is required.

2. All salvaged food, except as described in subsection 5, must be identified to indicate that the food has been salvaged by clearly marking the term "salvaged food" on all invoices, bills of lading, shipping invoices, receipts, and inventory records.

3. A person selling salvaged food at retail, except as described in subsection 5, shall notify the consumer that the food is salvaged either by labeling each retail package or container "salvaged" or "reconditioned" or posting a conspicuous placard at the retail display location stating "salvaged food" or "reconditioned food". Placards must be readable, using letters of not less than one and one-half-inch [3.81-centimeter] type. Placards must also state, "This item has been reconditioned and has been determined wholesome for human consumption under applicable state requirements by (name of food seller)".

4. All salvaged food in containers must be provided with labels that comply with the requirements contained in North Dakota Century Code chapter 19-02. If original labels are removed from containers that are to be resold or redistributed, the replacement labels must show as the distributor the name and address of the salvage food processor and the date of reconditioning for sale or distribution.

5. Subsections 2 and 3 do not apply to food products damaged in normal course of handling and transportation, where food is intact in its original container and has not been subject to

fire, chemical spills, temperature abuse in perishable food products, in contact with water, or other similar risk of contamination.

History: Effective March 1, 1996.
General Authority: NDCC 23-01-03
Law Implemented: NDCC 23-09-24

33-31-03-05. Recordkeeping requirements. A written record or receipt of distressed, salvageable, and salvaged food must be kept by the salvage food processor and distributor for inspection by the department during business hours. The records must include the name of the product, the source of the distressed food, the date received, the type of damage, the salvage process conducted, and the purchaser of the salvaged food. These records must be kept on the premises of the salvage food processor and distributor for a period of one year following the completion of transactions involving the food.

History: Effective March 1, 1996.
General Authority: NDCC 23-01-03
Law Implemented: NDCC 23-09-24

33-31-03-06. Salvage processing facilities and distributors outside the jurisdiction of the department. Salvaged merchandise from salvage processing facilities and distributors outside the jurisdiction of the department may be sold or distributed with the state if such facilities and distributors conform to the provisions of this code or substantially equivalent provisions. To determine the extent of compliance with such provisions, the department may accept reports from responsible authorities in other jurisdictions where such facilities and distributors operations are located.

History: Effective March 1, 1996.
General Authority: NDCC 23-01-03
Law Implemented: NDCC 23-09-24

TITLE 45

Commissioner of Insurance

APRIL 1996

CHAPTER 45-02-02

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

1. **Resident agents' applications.**

   a. An application must be completed in accordance with the instruction sheet and submitted on the insurance department's application form.

   b. An application may be submitted prior or subsequent to the applicant's testing date.

   c. An application for an agent's license by a partnership must be accompanied by a certified copy of the agreement.

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

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

   f. An application for a corporate or partnership agent's license must be completed on the department form.

g. A new application form is not required to add a new company unless adding an additional major category of insurance.

h. Every application must be accompanied by the appropriate fee.

2. **Nonresident agents' applications.**

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

b. An applicant for a nonresident agent's license must have the state, which issued the agent's resident license, supply to the department a certificate showing the lines for which the agent is licensed and eligible to write in that state.

c. A new application form is not required to add a new company unless adding an additional major category of insurance.

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

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

b. A broker's application must be accompanied by written proof of compliance with the requirement that the broker have in force a bond in the penal sum of ~~not less than two~~ five thousand dollars and the appropriate fee.

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

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

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

5. **Consultants' applications.**

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

b. No person, firm, corporation, or partnership holding a license as an agent, broker, surplus lines broker, or limited insurance representative may obtain and simultaneously hold a license as a consultant. If the applicant holds such licenses at the time of application, the licenses must be terminated prior to obtaining a consultant's license.

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

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

6. **Limited insurance representatives' applications.**

a. An application for a limited insurance representative must be submitted in accordance with the instruction sheet provided by the department and submitted on the appropriate form.

b. The applicant must clearly indicate in writing the specific area of insurance in which the applicant intends to conduct business and which must be exempt from the examination requirement.

7. **Temporary license applications.**

a. An application for a temporary insurance agent's or broker's license must be submitted in accordance with subdivisions a, b, c, d, e, and h of subsection 1, subsection 2, and subsection 3 and be accompanied by the appropriate fee.

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

c. A temporary license will not be granted for the sole reason that the applicant has failed to pass the agents'

examination and desires to be licensed until such time as a passing examination score is obtained.

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

45-02-02-08. Agent ~~or broker~~ - Sharing commission.

1. An agent may in isolated situations share a commission with another agent who has forwarded an insured's business to that agent where both agents are licensed for that line of insurance even though the forwarding agent may not be appointed by the company with which the business is placed.

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

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

CHAPTER 45-03-06

45-03-06-04. Credits.

1. The principal office ad valorem tax credit shall be used as a credit against the premium tax liability for the calendar year in which the ad valorem tax was paid. Any unused credit may be carried over as a credit against the premium tax liability for the following calendar years but not beyond 1985. North Dakota Century Code section 26.1-03-17 requires that the credit be prorated on a quarterly basis. Credit shall be used for each quarter and shall be fully reconciled, along with the premium tax, as of the end of each calendar year, on or before March first of the subsequent year.

2. The examination credit shall be used as a credit against the premium tax liability for the quarter in which expense was paid and the succeeding three quarters. The credit is limited to expenses incurred and paid to the North Dakota department of insurance. North Dakota Century Code section 26.1-03-17 requires that the credit be prorated on a quarterly basis. The credit shall be reconciled along with the premium tax as of the end of each calendar year, on or before March first of the subsequent year.

3. The credit for income tax or premium tax paid in 1983, on business done in 1982, shall first be taken as a credit against the tax liability under North Dakota Century Code section 26.1-03-17 for 1982, and the remaining credit against the tax liability for 1983 either on the quarterly estimates or at the time the tax is reconciled.

4. The credit taken for assessments paid to the comprehensive health association of North Dakota shall be taken in the calendar year in which paid and any remaining credit used as completely as possible in each succeeding year. Credit cannot be taken for any assessments paid prior to March 21, 1983.

5. The credit for assessments paid to the North Dakota life and health insurance guaranty association shall be twenty percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. ~~The credit shall be taken annually at the time the premium tax is reconciled for each calendar year.~~

6. Credit may be taken in the following year for miscalculations resulting in an overpayment in a preceding reconciliation submitted with the March first payment.

History: Effective September 1, 1983; amended effective April 1, 1996.
General Authority: NDCC 26.1-01-08
Law Implemented: NDCC 26.1-03-17

CHAPTER 45-03-17
EXAMINATIONS

[Repealed effective April 1, 1996]

CHAPTER 45-03-18

45-03-18-01. Application or renewal form to contain fire district number.

1. Applications for fire, allied, ~~multiple---peril--crop~~, homeowner's multiple peril, farmowner's multiple peril, commercial multiple peril, or crop hail insurance coverage for property in this state must identify by fire district number the fire district in which the property is located.

2. A company using an in-house system (electronic or manual) in its application process to identify and record the fire district number based upon the property location and value, complies with this section if the data is accurate, accessible, and readily verifiable.

3. Companies that use agents for reporting this information may use form NDFD300 (8/93) (appendix A).

4. For renewal business or changes not requiring a new application:

   a. Companies using agents to report the information may use form NDFD300 (8/93) (appendix A).

   b. Companies using an in-house system may do so subject to the requirements of subsection 2.

5. In lieu of form NDFD300 (8/93) (appendix A), the company may amend its application or use a substantially similar supplemental form of the company's own design.

History: Effective August 9, 1993; amended effective April 1, 1996.
General Authority: NDCC 26.1-01-07.5
Law Implemented: NDCC 26.1-01-07.5

Appendix A of Chapter 45-03-18 is amended as follows:

APPENDIX A

NORTH DAKOTA - Fire District Assignment
Supplement to Property Insurance Application

N.D.C.C. 26-1-01-07.5 requires:

After December 31, 1993, no insurer may issue or renew a policy for fire, allied lines, ~~multiple peril crop,~~ homeowner's multiple peril, farmowner's multiple peril, commercial multiple peril, or crop hail insurance coverage for property in this state unless the application identifies each fire district in which the insured property is located. The application must identify the property and insured value of the property located within each fire district if the policy provides coverage for property that is not all within a single district. For purposes of this section, "fire district" means rural fire protection district, city or area served by a certified rural fire department.

INSTRUCTIONS:

If all property insured is located in one Fire District, indicate Fire District in Column A, "ALL" in column B, and complete columns C and D.

If some of the insured property falls into different Fire Districts, indicate each Fire District in Column A. In columns B, C, and D, provide a breakout of the property in each district, its corresponding insured value, and proportionate premium.

Do not include Liability premium in column D.

Insurance Company: _____

Policy No. _____ New _____ Renewal _____

Named Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

A Fire District #	B Location of Property	C Insured Value of Property	D Property Premium

Agent: _____ Date: _____

NDFD300(12/95)

CHAPTER 45-06-01.1

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

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

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

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

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

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

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

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

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

reason other than nonpayment of premium or material misrepresentation.

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

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

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

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

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

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

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

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

2. **Minimum benefit standards.**

a. Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from

the sixty-first day through the ninetieth day in any medicare benefit period.

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

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

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

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

f. Coverage for the coinsurance amount of medicare eligible expenses under part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the medicare part B deductible (one hundred dollars).

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

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

45-06-01.1-06. Benefit standards for policies or certificates issued or delivered on or after January 1, 1992. The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards:

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

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

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

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

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

e. Each medicare supplement policy must be guaranteed renewable and:

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

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

   (3) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5 of subdivision e of subsection 1 of section 45-06-01.1-06, the issuer must offer certificate holders an individual medicare supplement policy which (at the option of the certificate holder):

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

      (b) Provides for such benefits as otherwise meets the requirements of this subsection.

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

(a) Offer the certificate holder the conversion opportunity described in paragraph 3 of subdivision e of subsection 1 of section 45-06-01.1-06; or

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

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

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

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

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

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

(3) Reinstitution of such coverages:

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

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

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

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

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

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

c. Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare part A eligible expenses for hospitalization paid at the diagnostic related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days.

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

e. Coverage for the coinsurance amount of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

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

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

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

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

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

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

   f. Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare.

   g. Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare.

   h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign county,

which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

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

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

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

(a) Fecal occult blood test or digital rectal examination.

(b) Mammogram.

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

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

(e) Serum cholesterol screening every five years.

(f) Thyroid function test.

(g) Diabetes screening.

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

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

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

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

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

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

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

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

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

(2) Coverage requirements and limitations.

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

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

(c) Coverage is limited to:

(i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The

total number of at-home recovery visits may not exceed the number of medicare-approved home health care visits under a medicare-approved home care plan of treatment.

(ii) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(iii) One thousand six hundred dollars per calendar year.

(iv) Seven visits in any one week.

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

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

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

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

(3) Coverage is excluded for:

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

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

k. New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost effective, and offered in a manner which is consistent with the goal of

simplification of medicare supplement policies. New or innovative benefits should offer uniquely different or significantly expanded coverages.

History: Effective January 1, 1992; amended effective April 1, 1996.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

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

1. **General rules.**

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

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

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

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

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

f. (1) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis~~,-other-than-incidentally,~~ to persons eligible for medicare ~~by--reason-of-age~~ must provide to such applicants a ~~medicare--supplement--buyer's~~ guide to health insurance for people with medicare in the form developed jointly by the national association of insurance commissioners and the health care financing administration and in a type size no smaller than twelve-point type. Delivery of the buyer's guide must be made whether or not such policies or certificates are advertised, solicited, or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the buyer's guide must be made to the applicant at the time of application and acknowledgment of receipt of the buyer's guide must be obtained by the insurer. Direct response issuers must deliver the buyer's guide to the applicant upon request but not later than at the time the policy is delivered.

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

2. **Notice requirements.**

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

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

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

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

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

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

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

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

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

c. The outline of coverage provided to applicants pursuant to this section must consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed below in no less than twelve-point type. All plans "A" through "J" must be shown on the cover page, and the plans that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

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

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s) _ _ _ _ [insert letter(s) of plan(s) being offered]

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

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

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

PREMIUM INFORMATION

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

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

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			$[716](Part A deductible)
First 60 days	All but $[716]	$0	$0
61st thru 90th day	All but $[179] a day	$[179] a day	
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:		100% of Medicare eligible expenses	
---Additional 365 days	$0		$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	$0	Up to $[89.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

[Bracketed amounts in Plans A through J are subject to change based on federal law and regulation.]

PLAN A

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

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

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

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716](Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	$0	Up to $[89.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN B

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

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

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

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716](Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	Up to $[89.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716] (Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day $0	$0
---Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0
---Additional 365 days			
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	Up to $[89.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN D

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

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

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

(continued)

PLAN D (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716] (Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0
---Additional 365 days			
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	Up to $[89.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN E

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

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

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

PARTS A & B

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

(continued)

PLAN E (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716] (Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	Up to $[89.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716] (Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	Up to $[89.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN G

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

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

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

(continued)

PLAN G (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716] (Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	Up to $[89.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN H

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

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

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

PARTS A & B

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

(continued)

PLAN H (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716] (Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	Up to $[89.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN I

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

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

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

(continued)

PLAN I (continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN J

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[716]	$[716] (Part A deductible)	$0
61st thru 90th day	All but $[179] a day	$[179] a day	$0
91st day and after:			
---While using 60 lifetime reserve days	All but $[358] a day	$[358] a day	$0
---Once lifetime reserve days are used:			
---Additional 365 days	$0	100% of Medicare eligible expenses	$0
---Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[89.50] a day	Up to $[89.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN J

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

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

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

PARTS A & B

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

(continued)

PLAN J (continued)

PARTS A & B (continued)

HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All costs
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

4. a. **Notice regarding policies or certificates** ~~which~~ that **are not medicare supplement policies.** Any accident and sickness insurance policy or certificate, other than a medicare supplement policy; or a policy issued pursuant to a contract under section 1876 or section 1833 of the Social Security Act [42 U.S.C. 1395 et seq.], disability income policy; ~~basic,--catastrophic,--or--major--medical expense-policy;--single--premium--nonrenewable--policy--or other---policy---identified--in--subsection-2--of--section 45-06-01.1-01,--issued--for--delivery--in--this--state--to persons-eligible-for-medicare-by-reason-of-age-must-notify insureds-under--the--policy--that--the--policy--is--not--a medicare--supplement-policy-or-certificate~~ or other policy identified in subsection 2 of section 45-06-01.1-01, issued for delivery in this state to persons eligible for medicare, must notify insureds under the policy that the policy is not a medicare supplement policy or certificate. ~~Such~~ The notice must either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. Such notice must be in no less than twelve-point type and must contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the ~~Medicare--Supplement--Buyer's~~ Guide to Health Insurance for People With Medicare available from the company."

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

History: Effective January 1, 1992; amended effective August 1, 1992; July 1, 1994; April 1, 1996.
General Authority: NDCC 26.1-36.1-03, 26.1-36.1-05
Law Implemented: NDCC 26.1-36.1-05

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

1. Application forms must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another medicare supplement or other health insurance policy or certificate in force or whether a medicare supplement policy or certificate

is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

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

2. If you ~~are 65 or older~~ purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

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

~~3.~~ 4. The benefits and premiums under your Medicare supplement policy ~~will~~ can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

~~4.~~ 5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid through the state Medicaid program, including benefits as a qualified medicare beneficiary (QMB) and a special low-income medicare beneficiary (SLMB).

[Questions]

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)?

   a. If so, with which company?

   b. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

2. Do you have any other health insurance ~~policies~~ that ~~provide~~ provides benefits ~~which~~ similar to this Medicare supplement policy ~~would duplicate~~?

   a. If so, with which company?

b. What kind of policy?

3. ~~If--the--answer--to--question-1--or--2-is-yes,-do-you intend-to-replace-these-medical--or--health--policies with--this-policy-[certificate]?~~ Are you covered for medical assistance through the state Medicaid program:

a. As a specified low-income medicare beneficiary (SLMB)?

b. As a qualified medicare beneficiary (QMB)?

c. For other Medicaid medical benefits?

~~4.---Are-you-covered-by-Medicaid?~~

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

a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

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

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

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

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

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

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

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

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction ~~does~~ will not duplicate coverage~~, to the best of my knowledge~~ because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ Other. (please specify)

_____
_____
_____

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

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

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

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

History: Effective January 1, 1992; amended effective July 1, 1994; April 1, 1996.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02, 26.1-36.1-05

STAFF COMMENT: Appendices A and B have been replaced. Appendix C is newly created but is not underscored so as to improve readability.

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE[1]_____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address_____ Person Completing Exhibit _____

Title_____ Telephone Number _____

line ----		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	C. Net (for reporting purposes = 1a - 1b)	_____	_____
2.	Past Years' Experience (All Policy Years)	_____	_____
3.	Total Experience (Net Current Year + Past Year's (Experience)	_____	_____

4. Refunds Last Year (Excluding Interest) _____

5. Previous Since Inception (Excluding Interest) _____

6. Refunds Since Inception (Excluding Interest) _____

7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1) _____

8. Experienced Ratio Since Inception _____

Total Actual Incurred Claims (line 3, col. b) = Ratio 2

Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)

9. Life Years Exposed Since Inception _____

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10. Tolerance Permitted (obtained from credibility table) _____

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE[1]_____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address_____ Person Completing Exhibit _____

Title_____ Telephone Number _____

11. Adjustment to Incurred Claims for Credibility _____

Ratio 3 = Ratio 2 + Tolerance

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

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

12. Adjusted Incurred Claims _____

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

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

Adjusted Incurred Claims (line 12)

Benchmark Ratio (Ratio 1) _____

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

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

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

_____
Signature

_____
Name - Please Type

_____
Title

_____
Date

Replace Appendix B - Form for Reporting Medicare Supplement Policies with the following page:

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR_____
TYPE[1] SMSBP[2]

For the State of_____ Company Name _____
NAIC Group Code _____ _____ NAIC Company Code _____
Address_____ Person Completing Exhibit _____
Title_____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

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

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
[3]Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5]These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

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

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

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

[1]Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2]"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
[3]Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4]For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5]These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

Appendix C is created and includes the following pages:

APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Federal law, P.L. 103-432, prohibits the sale of a health insurance policy (the term policy or policies includes certificates) that duplicate Medicare benefits unless it will pay benefits without regard to other health coverage and it includes the prescribed disclosure statement on or together with the application.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. The federal law does not pre-empt state laws that are more stringent than the federal requirements.

7. The federal law does not pre-empt existing state form filing requirements.

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for specified limited services]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for both expenses incurred and fixed indemnity basis]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for both expenses incurred and fixed indemnity basis]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For long-term care policies providing both nursing home and non-institutional coverage]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies providing nursing home benefits only]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies providing home care benefits only]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For other health insurance policies not specifically identified in the previous statements]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

45-06-07-04. Requirements for contracts and evidence of coverage. Each subscriber is entitled to receive an individual contract or evidence of coverage in a form that has been approved by the commissioner. Each group contractholder is entitled to receive a group contract as approved by the commissioner. Group contracts, individual contracts, and evidences of coverage must be delivered or issued for delivery to subscribers or group contractholders within a reasonable time after enrollment, but not more than fifteen days from the later of the effective date of coverage or the date on which the health maintenance organization is notified of enrollment.

1. **Health maintenance organization information.** The group or individual contract and evidence of coverage must contain the name, address, and telephone number of the health maintenance organization, and where and in what manner information is available as to how services may be obtained. A telephone number within the service area for calls, without charge to members, to the health maintenance organization's administrative office must be made available and disseminated to enrollees to adequately provide telephone access for enrollee services, problems, or questions. A health maintenance organization shall provide a method by which the enrollee may contact the health maintenance organization at no cost to the enrollee. This may be done through the use of toll-free or collect telephone calls. The enrollee must be informed of the method by notice in the handbook, newsletter, or flyer. The group or individual contract or evidence of coverage may indicate the manner in which the number will be disseminated rather than list the number itself.

2. **Eligibility requirements.**

   a. The group or individual contract and evidence of coverage must contain eligibility requirements indicating the conditions that must be met to enroll as a subscriber or eligible dependent, the limiting age for subscribers and eligible dependents including the effects of medicare eligibility, and a clear statement regarding coverage of newborn and adopted children.

   b. A group or individual contract or evidence of coverage may not contain any provision excluding or limiting coverage for a newborn child or adopted child. Medically diagnosed congenital defects and birth abnormalties must be treated the same as any other illness or injury for which coverage is provided. The group or individual contract and evidence of coverage may require that notification of birth of a newborn child or the placement for adoption of a child and payment of any required premium must be

furnished to the health maintenance organization within thirty-one days after the date of birth or placement for adoption in order to have coverage continue beyond such thirty-one-day period. The health maintenance organization is entitled to premium for the first thirty-one days of coverage, unless the coverage is rejected by the subscriber prior to the birth or placement for adoption of the child.

c. The definition of an eligible dependent must include:

(1) The spouse of the subscriber.

(2) An unmarried dependent child of the subscriber, including a dependent of an unmarried child who:

(a) Has not reached age ~~nineteen~~ twenty-two;

(b) Has reached age sixteen through age ~~twenty-three~~ twenty-six who is attending a recognized college or university, trade school, or secondary school on a full-time basis; or

(c) Has reached age ~~nineteen~~ twenty-two but who is incapable of self-support because of mental retardation, mental illness, or physical incapacity which began before the child reached age ~~nineteen~~ twenty-two, and who is chiefly dependent upon the subscriber for support and maintenance.

d. The definition of a dependent child of a subscriber must include a child who:

(1) Is related to the subscriber as a natural child, a child placed for adoption, or a stepchild;

(2) Resides in the subscriber's household and who qualifies as a dependent of the subscriber or the subscriber's spouse under the United States Internal Revenue Code and the federal tax regulations; or

(3) Is eligible by virtue of a court order making the subscriber responsible for health care services for the dependent child.

3. **Benefits and services within the service area.** The group or individual contract and evidence of coverage must contain a specific description of benefits and services available within the service area.

4. **Emergency care benefits and services.** The group or individual contract and evidence of coverage must contain a specific

description of benefits and services available for emergencies twenty-four hours a day, seven days a week, including disclosure of any restrictions on emergency care services. A group or individual contract or evidence of coverage may not limit the coverage of emergency services within the service area to affiliated providers only.

5. **Out-of-area benefits and services.** The group or individual contract and evidence of coverage must contain a specific description of benefits and services available out of the service area.

6. **Copayments and deductibles.** The group or individual contract and evidence of coverage must contain a description of any copayments or deductibles that must be paid by enrollees.

7. **Limitations and exclusions.** The group or individual contract and evidence of coverage must contain a description of any limitations or exclusions on the services, kind of services, benefits, or kind of benefits including any limitations or exclusions due to preexisting conditions, waiting periods, or an enrollee's refusal of treatment.

8. **Enrollee termination.**

   a. A health maintenance organization may not cancel or terminate coverage of services provided an enrollee under a health maintenance organization group or individual contract except for one or more of the following reasons:

      (1) Failure to pay the amounts due under the group or individual contract.

      (2) Fraud or material misrepresentation in enrollment or in the use of services or facilities.

      (3) Material violation of the terms of the group or individual contract.

      (4) Failure to meet the eligibility requirements under a group contract.

      (5) Termination of the group contract under which the enrollee was covered.

      (6) Failure of the enrollee and the primary care physician to establish a satisfactory patient-physician relationship if:

         (a) It is shown that the health maintenance organization has, in good faith, provided the enrollee with the opportunity to select an alternative primary care physician;

(b) The enrollee has repeatedly refused to follow the plan of treatment ordered by the physician; and

(c) The enrollee is notified in writing at least thirty days in advance that the health maintenance organization considers the patient-physician relationship to be unsatisfactory and specific changes are necessary in order to avoid termination.

(7) Such other good cause agreed upon in the group or individual contract and approved by the commissioner.

However, coverage may not be canceled or terminated on the basis of the status of the enrollee's health or because the enrollee has exercised the enrollee's rights under the health maintenance organization's grievance procedure by registering a grievance against the health maintenance organization.

b. A health maintenance organization may not cancel or terminate an enrollee's coverage for services provided under a health maintenance organization group or individual contract without giving the enrollee at least fifteen days' written notice of such termination. Notice will be considered given on the date of mailing or, if not mailed, on the date of delivery. This notice must include the reason for termination. If termination is due to nonpayment of premium, the grace period required in subsection 23 of section 45-06-07-04 applies. Advance notice of termination is not required to be given for termination due to nonpayment of premium.

c. A health maintenance organization may not terminate coverage of a dependent child upon attainment of the limiting age if the child is and continues to be both:

(1) Incapable of self-support because of mental retardation, mental illness, or physical incapacity; and

(2) Chiefly dependent upon the subscriber for support and maintenance.

Proof of such incapacity and dependency must be furnished to the health maintenance organization by the subscriber within thirty-one days of the child's attainment of the limiting age and subsequently as reasonably required by the health maintenance organization.

9. **Enrollee reinstatement.** If a health maintenance organization permits reinstatement of an enrollee's coverage, the group or

individual contract and evidence of coverage must include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the health maintenance organization and that the health maintenance organization is not obligated to reinstate any terminated coverage.

10. **Claims procedures.** The group or individual contract and evidence of coverage must contain procedures for filing claims that include:

    a. Any required notice to the health maintenance organization.

    b. If any claim forms are required, how, when, and where to obtain and submit them.

    c. Any requirements for filing proper proofs of loss.

    d. Any time limit of payment of claims.

    e. Notice of any provisions for resolving disputed claims, including arbitration.

    f. A statement of restrictions, if any, on assignment of sums payable to the enrollee by the health maintenance organization.

11. **Enrollee grievance procedures and arbitration.** In compliance with subsection 4 of section 45-06-07-09, the group or individual contract and evidence of coverage must contain a description of the health maintenance organization's method for resolving enrollee grievances, including procedures to be followed by the enrollee in the event any dispute arises under the contract, including any provisions for arbitration.

12. **Continuation of coverage.** A group contract and evidence of coverage must contain a provision that any enrollee who is an inpatient in a hospital or a skilled nursing facility on the date of discontinuance of the group contract must be covered in accordance with the terms of the group contract until discharged from such hospital or skilled nursing facility. The enrollee may be charged the appropriate premium for coverage that was in effect prior to discontinuance of the group contract.

13. **Conversion of coverage.**

    a. The group or individual contract and evidence of coverage must contain a conversion provision that provides that each enrollee has the right to convert coverage to an individual health maintenance organization contract in the following circumstances:

(1) Upon termination of eligibility for coverage under a group or individual contract; or

(2) Upon termination of the group contract.

To obtain the conversion contract, an enrollee shall submit a written application and the applicable premium payment to the health maintenance organization within thirty-one days after the date the enrollee's eligibility for coverage terminates.

b. A conversion contract is not required to be made available if:

(1) The enrollee's termination of coverage occurred for any of the reasons listed in paragraphs 1, 2, 3, 6, and 7 of subdivision a of subsection 8 of section 45-06-07-04;

(2) The enrollee is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act (medicare);

(3) The enrollee is covered by or is eligible for similar hospital, medical, or surgical benefits under state or federal law;

(4) The enrollee is covered by or is eligible for similar hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group;

(5) The enrollee is covered for similar benefits by an individual policy or contract; or

(6) The enrollee has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

c. The conversion contract must provide basic health care services to its enrollees as a minimum.

d. The conversion contract must begin coverage of the enrollee formerly covered under the group or individual contract on the date of termination from such group or individual contract.

e. Coverage must be provided without requiring evidence of insurability and may not impose any preexisting condition limitations or exclusions as described in subsection 1 of section 45-06-07-05 other than those remaining unexpired under the contract from which conversion is exercised. Any probationary or waiting period set forth in the conversion contract must be deemed to commence on the

effective date of the enrollee's coverage under the prior group or individual contract.

f. If a health maintenance organization does not issue individual or conversion contracts, the health maintenance organization may use a noncancelable group contract to provide coverage for enrollees who are eligible for conversion coverage.

14. **Extension of benefits for total disability.**

a. Each group contract issued by a health maintenance organization must contain a reasonable extension of benefits upon discontinuance of the group contract with respect to enrollees who become totally disabled while enrolled under the contract and who continue to be totally disabled at the date of discontinuance of the contract.

b. Upon payment of premium at the current group rate, coverage must remain in full force and effect until the first of the following to occur:

(1) The end of a period of twelve months starting with the date of termination of the group contract;

(2) The date the enrollee is no longer totally disabled; or

(3) The date a succeeding carrier provides replacement coverage to that enrollee without limitation as to the disabling condition.

c. Upon termination of the extension of benefits, the enrollee must have the right to convert coverage as provided in subsection 13.

15. **Coordination of benefits.** The group or individual contract and evidence of coverage may contain a provision for coordination of benefits that is consistent with that applicable to other carriers in the jurisdiction. Any provisions or rules for coordination of benefits established by a health maintenance organization may not relieve a health maintenance organization of its duty to provide or arrange for a covered health care service to any enrollee because the enrollee is entitled to coverage under any other contract, policy, or plan, including coverage provided under government programs. The health maintenance organization is required to provide covered health care services first and then, at its option, seek coordination of benefits.

16. **Subrogation for injuries caused by third parties.** The group or individual contract and evidence of coverage may not contain any provisions concerning subrogation for injuries

caused by third parties unless the wording has been approved by the commissioner.

17. **Description of the service area.** The group or individual contract and evidence of coverage must contain a description of the approved service area.

18. **Entire contract provision.** The group or individual contract must contain a statement that the contract, all applications, and any amendments constitute the entire agreement between the parties. A portion of the charter, bylaws, or other document of the health maintenance organization may not be part of such a contract unless set forth in full in the contract or attached to the contract. However, the evidence of coverage may be attached to and made a part of the group contract.

19. **Term of coverage.** The group or individual contract and evidence of coverage must contain the time and date or occurrence upon which coverage takes effect, including any applicable waiting periods, or describe how the time and date or occurrence upon which coverage takes effect is determined. The contract and evidence of coverage must also contain the time and date or occurrence upon which coverage will terminate.

20. **Cancellation or termination.** The group or individual contract must contain the conditions upon which cancellation or termination may be effected by the health maintenance organization, the group contractholder, or the subscriber.

21. **Renewal.** The group or individual contract and evidence of coverage must contain the conditions for, and any restrictions upon, the subscriber's right to renewal.

22. **Reinstatement of group or individual contractholder.** If a health maintenance organization permits reinstatement of a group or individual, the contract and evidence of coverage must include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the health maintenance organization and that the health maintenance organization is not obligated to reinstate any terminated contract.

23. **Grace period.**

    a. The group or individual contract must provide for a grace period of not less than thirty-one days for the payment of any premium except the first, during which time the coverage must remain in effect if payment is made during the grace period. The evidence of coverage must include notice that a grace period exists under the group contract

and that coverage continues in force during the grace period.

b. During the grace period:

(1) The health maintenance organization remains liable for providing the services and benefits contracted for;

(2) The contractholder remains liable for the payment of premium for coverage during the grace period; and

(3) The subscriber remains liable for any copayments and deductibles.

c. If the premium is not paid during the grace period, coverage is automatically terminated at the end of the grace period. Following the effective date of such termination, the health maintenance organization shall deliver written notice of termination to the contractholder.

24. **Conformity with state law.** Any group or individual contract and evidence of coverage delivered or issued for delivery in this state must include a provision that states that any provision not in conformity with North Dakota Century Code chapter 26.1-18.1, this chapter, or any other applicable law or rule in this state may not be rendered invalid but be must construed and applied as if it were in full compliance with the applicable laws and rules of this state.

25. **Right to examine contract.** An individual contract must contain a provision stating that a person who has entered into an individual contract with a health maintenance organization must be permitted to return the contract within ten days of receiving it and to receive a refund of the premium paid if the person is not satisfied with the contract for any reason. If the contract is returned to the health maintenance organization or to the agent through whom it was purchased, it is considered void from the beginning. However, if services are rendered or claims are paid for such person by the health maintenance organization during the ten-day examination period and the person returns the contract to receive a refund of the premium paid, the person must be required to pay for such services.

History: Effective July 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-06-07-05. Prohibited practices.

1. **Preexisting conditions.**

   a. A health maintenance organization may include in its individual contract a provision setting forth reasonable exclusions or limitations of services for preexisting conditions at the time of enrollment. However, such exclusions or limitations may not be for a period greater than ~~two-years~~ twelve months.

   b. A health maintenance organization may not exclude or limit services for a preexisting condition when the enrollee transfers coverage from one individual contract to another or when the enrollee converts coverage under the enrollee's conversion option, except to the extent of a preexisting condition limitation or exclusion remaining unexpired under the prior contract. Any required probationary or waiting period must be deemed to have commenced on the effective date of coverage under the prior contract. The health maintenance organization contract must disclose any preexisting condition limitations or exclusions that are applicable when an enrollee transfers from a prior health maintenance organization contract.

   c. A preexisting condition may not be defined more restrictively than a disease or physical condition ~~for which--medical--advice--or--treatment-was-recommended-by-a physician-or-received-from-a-physician~~ that was diagnosed or treated within a ~~two-year~~ six-month period preceding the effective date of coverage under the health care plan.

   d. A preexisting condition period must be reduced for any time period already served under qualifying previous coverage as defined by subsection 23 of North Dakota Century Code section 26.1-36.3-01 if the qualifying previous coverage is continuous at least ninety days before the effective date of the new coverage.

   e. A group contract or evidence of coverage may not exclude or limit services for a preexisting condition.

2. **Unfair discrimination.** A health maintenance organization may not unfairly discriminate against any enrollee or applicant for enrollment on the basis of the age, sex, race, color, creed, national origin, ancestry, religion, marital status, or lawful occupation of an enrollee, or because of the frequency of utilization of services by an enrollee. However, a health maintenance organization is not prohibited from setting rates or establishing a schedule of charges in accordance with relevant actuarial data. A health maintenance organization may not expel or refuse to reenroll any enrollee nor refuse to enroll individual members of a group on the basis of the

health status or health care needs of the individuals or enrollees.

History: Effective July 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-09-01-09. Statement of taxable premiums. Surplus lines brokers are required by North Dakota Century Code section 26.1-44-06 to file annually a statement of taxable premiums received by that broker (Appendix V).

History: Effective January 1, 1982; amended effective April 1, 1996.
General Authority: NDCC 26.1-44-09
Law Implemented: NDCC 26.1-44-06

APPENDIX I

STATE OF NORTH DAKOTA

Department of Insurance

Bismarck, ND 58505

APPLICATION FOR SURPLUS LINES BROKER'S LICENSE

Under the provisions of North Dakota Century Code chapters 26.1-26 and 26.1-44, application is hereby made for a surplus lines broker's license.

The applicant hereby affirms that applicant has read, and is familiar with, the provisions of North Dakota Century Code chapters 26.1-26 and 26.1-44, which govern the placement of insurance with nonadmitted companies, in particular the following requirements:

1. Before license may be issued there must be deposited with the commissioner of insurance a bond in the ~~penal sum of an amount of not less than an amount equal to the taxes paid to the commissioner the previous year as required by North Dakota Century Code section 29-09.2-07, with a minimum bond of five hundred dollars and a maximum of twenty thousand dollars~~ not less than five thousand dollars. The bond ~~shall~~ must be in such form and with such sureties as may be acceptable to the commissioner~~, and annually a certificate of continuation of said bond shall be submitted to this department~~ and must be kept in force for as long as the license remains in effect.

2. Each surplus lines broker shall file a certificate of insurance with the commissioner, and shall keep in force for as long as the license remains in effect, an errors and omissions insurance policy in an amount not less than five hundred thousand dollars.

3. Licenses expire annually on April thirtieth, and must be renewed on or before May first if they are to continue uninterruptedly.

~~3.~~ 4. On each risk placed under a surplus lines license, the broker must make affidavit, in a form acceptable to the commissioner of insurance that after reasonable diligent search, the risk cannot be placed with a licensed company. Only after the commissioner of insurance concurs in the allegations contained in the affidavit can the broker proceed to place the risk with the nonadmitted company.

4. 5. Each policy issued under a surplus lines license must be endorsed, "Issued with a nonadmitted company under Broker's License No. ____" which endorsement must be filed in and signed by the broker.

5. 6. The broker is required to keep a separate record of business transacted under the broker's surplus lines license, and on or before April first of each year, must file with the commissioner of insurance a statement for the preceding calendar year ending on December thirty-first, giving the name of the insured to whom each policy has been issued, the name and home office of each company issuing any such policy, the amount of such insurance, the rates charged therefore, the gross premiums charged, and the date and term of the policy and the amount of premium returned on each policy canceled or not taken, together with such other information and upon such form as required by the commissioner of insurance.

6. 7. At the time of filing the above statement, the broker is required to pay the tax (current rate two and one-half percent) on the premium so written on risks or exposures located in this state.

7. 8. The broker is personally responsible for investigating the financial condition of the nonadmitted insurer before placing the insurance therewith. The company must have capital and surplus amounting to at least the amount required of a licensed carrier transacting the same class of business.

8. 9. Before a company can be qualified as a nonadmitted surplus lines outlet, it must appoint the commissioner of insurance in writing to be its true and lawful attorney, upon whom legal process in any action or preceding against it may be served.

9. 10. The commissioner of insurance may inspect and examine at any time a broker's records of business transacted under the surplus lines license.

10. 11. The penalties for making a false affidavit include revocation of license, and failure to make and file the required annual statement or to pay the taxes required prior to May first, can result in a fine of twenty-five dollars per day for each day of the delinquency.

The applicant is presently licensed to represent the following licensed companies:

1._____	6._____
2._____	7._____
3._____	8._____
4._____	9._____
5._____	10._____

Remittance of ten dollars covering the statutory fee for issuance of the surplus lines license is attached hereto.

SIGNED: _____

_____
Date of Application

_____
Name

_____
Address

APPENDIX IIa

BOND NUMBER _____

_____ BOND

KNOW ALL MEN BY THESE PRESENTS:

That we, _____, as Principal, and _____, licensed to do a surety business in the State of North Dakota, as Surety, are held and firmly bound unto the State of North Dakota for the benefit of any aggrieved party in the sum of _____ ($_____) for the payment of which we hereby bind ourselves, our heirs, administrators, executors, assigns and successors jointly and severally by these presents this _____ day of _____, 19___.

THE CONDITIONS OF THIS OBLIGATION ARE SUCH THAT, if the above bonded _____, presently applying for _____ license under North Dakota Century Code chapter 26.1-26, shall faithfully conform to and abide by each and every provision of that chapter and any other applicable laws, and shall pay to the State of North Dakota for the benefit of any aggrieved party any and all moneys that may become due or owing to said aggrieved party under and by virtue of the provisions of said laws, then this obligation shall be null and void; otherwise to remain in full force and effect.

Provided, however, that this Suretyship may be terminated by the Surety upon thirty days written notice to the obligee and the Principal, or by the obligee upon notice in writing within ten working days to the Surety specifying the date of termination.

SIGNED THIS _____ DAY OF _____, 19 ___.

_____
Principal

_____
Surety

COUNTERSIGNED:

_____
Attorney-in-fact

_____
North Dakota Resident Agent or Broker

1. INSURANCE BROKER'S BOND ~~shall~~ must be in the amount of ~~two~~ five thousand dollars with an authorized corporate surety approved by the commissioner and must be kept in force for as long as the license remains in effect.

2. SURPLUS LINES INSURANCE BROKER'S BOND ~~shall~~ must be in the amount of not less than ~~an amount equal to the taxes paid to~~

~~the commissioner the previous year as required by North Dakota Century Code section 26.1-44-06, with a minimum bond of five hundred dollars and a maximum of twenty thousand dollars. A surplus lines broker applying for one's first license shall furnish a bond in an amount as determined by the commissioner~~ five thousand dollars with an authorized corporate surety approved by the commissioner and must be kept in force for as long as the license remains in effect.

3. COMBINATION INSURANCE BROKER'S BOND and SURPLUS LINES INSURANCE BROKER'S BOND ~~shall~~ must be in the amount of ~~twenty~~ not less than ten thousand dollars and must be kept in force for as long as the license remains in effect.

4. Each surplus lines broker shall file a certificate of insurance with the commissioner, and shall keep in force for as long as the license remains in effect, an errors and omissions insurance policy in an amount not less than five hundred thousand dollars.

ACKNOWLEDGMENT FOR INDIVIDUAL AND COPARTNERSHIP

STATE OF _____)
ss.
COUNTY OF _____)

On this _____ day of _____, 19 ___, before me, a Notary Public in and for said State and County, personally appeared _____ known to me to be the person _____ who _____ described in and who executed the within instrument, and acknowledged to me that _____ he _____ executed the same.

_____
Notary Public

ACKNOWLEDGMENT FOR CORPORATION

STATE OF _____)
ss.
COUNTY OF _____)

On this _____ day of _____, 19 ___, personally appeared before me _____, to me personally known, who being by me duly sworn, did depose and say, he or she is _____ of _____ the corporation described in and which executed the foregoing instrument, that the seal affixed to the instrument is the corporate seal of the corporation, that the instrument was signed and sealed in behalf of the corporation by authority of its board of directors, and the corporation acknowledged the instrument to be free act and deed of the corporation.

_____
Notary Public

ACKNOWLEDGMENT OF SURETY

STATE OF _____)
ss.
COUNTY OF _____)

On this _____ day of _____, 19 ___, before me appeared _____, to me personally known, who being by me duly sworn did say that he or she is Attorney-in-fact for the _____ the corporation described in and which executed the foregoing instrument, that the seal affixed to the instrument is the corporate seal of the corporation, that the instrument was signed and sealed in behalf of the corporation by authority of its board of directors, and he or she acknowledged the instrument to be free act and deed of the corporation.

_____
Notary Public

CHAPTER 45-12-01

45-12-01-01. Definitions. As used in this article:

1. "Alteration" means a structural modification of or a departure from an original or existing construction.

2. "Apartments" means all multiple dwellings, including condominiums.

3. "Approved" means approved by the commissioner.

4. "A.S.M.E. Code" means the Boiler and Pressure Vessel Construction Code of the American society of mechanical engineers of which sections I, II, IV, V, VIII (divisions 1 and 2), and IX, ~~1992~~ 1995 edition, are hereby adopted by the commissioner and incorporated by reference as a part of this article. A copy of the American Society of Mechanical Engineers Code is on file at the office of the boiler inspection program. The American Society of Mechanical Engineers Code may be obtained from the American society of mechanical engineers headquarters at 345 east forty-seventh street, New York, New York 10017.

5. "Boiler" means a closed vessel in which water is heated, steam is generated, steam is superheated, or any combination thereof, under pressure or vacuum for use externally to itself by the direct application of heat from the combustion of fuels or from electricity or nuclear energy. The term boiler includes fired units for heating or vaporizing liquids other than water where these units are separate from processing systems and are complete within themselves, as provided under North Dakota Century Code section 26.1-22.1-01.

6. "Certificate inspection" means an inspection, the report of which is used by the chief boiler inspector to decide whether a certificate may be issued under North Dakota Century Code section 26.1-22.1-10.

7. "Certificate of competency" means a certificate issued by a jurisdiction indicating that a person has passed an examination prescribed by the national board of boiler and pressure vessel inspectors.

8. "Chief inspector" means the chief boiler inspector appointed by the commissioner to serve in the capacity as stated by law.

9. "Commissioner" means the commissioner of insurance of North Dakota.

10. "Condemned boiler" means a boiler that has been inspected and declared unsafe or disqualified by legal requirements by an inspector qualified to take such action who has applied a stamping or marking designating its rejection.

11. "Deputy inspector" means a boiler inspector or inspectors employed by the commissioner to assist the chief inspector in making inspections of boilers.

12. "Existing installations" includes any boiler constructed, installed, or placed in operation before July 1, 1973.

13. "External inspection" means an inspection made when a boiler is in operation.

14. "Fusion welding" means a process of welding metals in a molten or molten and vaporous state, without the application of mechanical pressure or blows. Such welding may be accomplished by the oxyacetylene or oxyhydrogen flame or by the electric arc. Thermic welding is also classed as fusion.

15. "High pressure, high temperature water boiler" means a water boiler operating at pressures exceeding one hundred sixty pounds per square inch gauge [1103.17 kilopascals] or temperatures exceeding two hundred fifty degrees Fahrenheit [121.16 degrees Celsius]. For practical purposes it must be deemed the same as a power boiler.

16. "Hot water supply boiler" means a fired boiler used exclusively to supply hot water for purposes other than space heating and includes all service and domestic-type water heaters not otherwise exempt by North Dakota Century Code section 26.1-22.1-06.

17. "Inspector" means the chief boiler inspector or any deputy inspector or special inspector.

18. "Internal inspection" means an inspection made when a boiler is shut down and handholes and manholes are opened for inspection of the interior.

19. "Low pressure and heating boiler" means a boiler operated at pressures not exceeding fifteen pounds per square inch gauge [103 kilopascals] for steam or at pressures not exceeding one hundred sixty pounds per square inch gauge [1103.17 kilopascals] and temperatures not exceeding two hundred fifty degrees Fahrenheit [121.1 degrees Celsius] for water.

20. "Major repair" means a repair upon which the strength of a boiler would depend. Major repairs are those that are not of a routine nature as described in ~~chapter III of~~ the National Board Inspection Code. ~~The National Board Inspection Code,~~

~~1992--edition,--is--hereby--adopted--by--the--commissioner-and incorporated-by-reference-as-a-part-of-this-article.~~

21. "Miniature boiler" means any boiler that does not exceed any of the following limits:

    a. Sixteen-inch [40.64-centimeter] inside diameter of shell.

    b. Twenty square feet [1.86 square meter] heating surface.

    c. Five cubic feet [.142 cubic meter] gross volume, exclusive of casing and insulation.

    d. One hundred pounds per square inch gauge [689.48 kilopascals] maximum allowable working pressure.

22. "National board" means the national board of boiler and pressure vessel inspectors, 1055 crupper avenue, Columbus, Ohio 43229, whose membership is composed of the chief inspectors of government jurisdictions who are charged with the enforcement of the provisions of the American Society of Mechanical Engineers Code.

23. "National Board Inspection Code" means the manual for boiler and pressure vessel inspectors supplied by the national board. The National Board Inspection Code, 1995 edition, is hereby adopted by the commissioner and incorporated by reference as a part of this article. Copies of this code may be obtained from the national board at 1055 crupper avenue, Columbus, Ohio 43229.

24. "New boiler installations" includes all boilers constructed, installed, or placed in operation after July 1, 1973.

25. "Nonstandard boiler" means a boiler that does not bear the state stamp, the national board stamping, the American society of mechanical engineers stamp or the stamp of any state or political subdivision which has adopted a standard of construction equivalent to that required by this article.

26. "Owner or user" means any person, firm, corporation, state, or political subdivision owning or operating any boiler which is not specifically exempt under North Dakota Century Code section 26.1-22.1-06 within North Dakota.

27. "Power boiler" means a closed vessel in which steam or other vapor (to be used externally to itself) is generated at a pressure of more than fifteen pounds per square inch gauge [103 kilopascals] by the direct application of heat.

28. "Reciprocal commission" means a commission issued by the commissioner to persons who have passed a written examination prescribed by the national board and who hold a national board

commission issued by the national board, or to persons who have passed the written examination prescribed by the national board and are employed by a self-insured corporation making their own inspections.

29. "Reinstalled boiler" means a boiler removed from its original setting and reerected at the same location or erected at a new location without change of ownership.

30. "Reinstalled pressure vessel" means a pressure vessel removed from its original setting and reerected at the same location or erected at a new location without change of ownership.

31. "Repair" is a restoration of any damaged or impaired part to an effective and safe condition.

~~31.~~ 32. "Secondhand boiler" means a boiler of which both the location and ownership have been changed after primary use.

33. "Secondhand pressure vessel" means a pressure vessel of which both the location and ownership have been changed after primary use.

~~32.~~ 34. "Service-type or domestic-type water heater" means a fired water heater of either instantaneous or storage type, used for heating or combined heating and storage of hot water to be used exclusively for domestic or sanitary purposes, with temperatures not exceeding two hundred ten degrees Fahrenheit [98.68 degrees Celsius], and a heat input not in excess of two hundred thousand British thermal units [2.11 x 10 to the 8th power joules] per hour, and pressure not to exceed one hundred sixty pounds per square inch [1103.17 kilopascals].

~~33.~~ 35. "Special inspector" means an inspector regularly employed by an insurance company authorized to insure against loss from explosion of boilers in this state or an inspector who has passed the national board examination and is employed by a self-insured corporation.

~~34.~~ 36. "Standard boiler" means a boiler that bears the stamp of North Dakota or of another state that has adopted a standard of construction equivalent to that required by this article or a boiler that bears the national board stamping or American society of mechanical engineers stamp.

~~35.~~ 37. "State of North Dakota Boiler Construction Code" is used to designate the accepted reference for construction, installation, operation, and inspection of boilers and will be referred to as this article. Anything not amended or specifically covered in this article must be considered the same as the American Society of Mechanical Engineers Code.

~~36.~~ 38. "Steam traction engines" means boilers on wheels which are used solely for show at state fairs and other exhibitions in which the public is invited to attend.

History: Effective June 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

45-12-02-20. Welders' requirements.

1. Any person welding on new or existing boilers shall register with the chief boiler inspector sufficient data to show a satisfactory performance qualification test for American society of mechanical engineers position "6G" or equivalent. This data must be documented on a current American society of mechanical engineers section IX "QW-484" form. Tests of welded specimens must be made by a certified testing laboratory.

2. In lieu of the above requirements, a firm in possession of a valid American society of mechanical engineers certificate of authorization for new boiler construction or a valid national board "R" certificate of authorization for repairing or altering existing boilers may allow welder's qualifications to be audited by the chief boiler inspector at the chief boiler inspector's discretion. The welders must be qualified according to the requirements of American Society of Mechanical Engineers Boiler and Pressure Vessel Code, section IX.

History: Effective June 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

45-12-03-07. Automatic low-water fuel cutoff or water-feeding device.

1. Each automatically fired steam or vapor system boiler must be equipped with an automatic low-water cutoff located to automatically cut off the fuel supply when the surface of the water falls to the lowest safe waterline. Each automatically fired high pressure boiler must be equipped with at least two low-water fuel cutoffs, one of which must be ~~of the float type~~ readily testable. A high pressure boiler regularly attended by a full-time operator is not considered as automatically fired, and is not required to be equipped with low-water fuel cutoffs. For other than electric boilers, the primary low-water fuel cutoff for low pressure steam boilers must be a float type that can be readily tested.

2. If a water-feeding device is installed, it must be constructed so that the water inlet valve cannot feed water into the boiler through the float chamber and located to supply requisite feedwater. The lowest safe waterline should not be lower than the lowest visible part of the water glass.

3. Such fuel or feedwater control device may be attached directly to a boiler or to the tapped openings provided for attaching a water glass directly to a boiler, provided that for low pressure boilers such connections from the boiler are nonferrous tees or Y's not less than one-half-inch [12.7-millimeter] pipe size between the boiler and the water glass, so that the water glass is attached directly and as close as possible to the boiler; the straightway tapping of the Y or tee to take the water glass fittings, and the side outlet of the Y or tee to take the fuel cutoff or water-feeding device. The ends of all nipples must be reamed to full-size diameter.

4. Designs embodying a float and float bowl must have a vertical straightaway drainpipe at the lowest point in the water equalizing pipe connections by which the bowl and the equalizing pipe can be flushed and the device tested.

History: Effective June 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

45-12-03-26. Inspection of boilers.

1. Each boiler used or proposed to be used within this state, except boilers exempt in North Dakota Century Code section

26.1-22.1-06, must be thoroughly inspected as to their construction, installation, condition, and operation as follows:

a. Power boilers must be inspected annually both internally ~~and externally~~ while not under pressure and ~~must also be inspected annually~~ externally while under pressure. However, any power boiler or steam generator, the operation of which is an integral part of or a necessary adjunct to other continuous processing operations, must be inspected internally at such intervals as are permitted by the shutting down of the processing operation. The chief boiler inspector may provide for extension of time between internal inspections, but an external inspection must be made, and report submitted, for purposes of issuing a certificate. In all other instances the certificate inspection must be an internal inspection when construction permits.

b. Power boilers of one hundred thousand pounds [45359.24 kilograms] per hour or more capacity, which comply with subsection 2 of North Dakota Century Code section 26.1-22.1-07, must be inspected at least once every thirty-six months internally while not under pressure and at least once every twelve months externally while under pressure.

c. Steam traction engines must be inspected at least once every twenty-four months. Inspections must alternate between internal inspections and hydrostatic tests. External inspections, made with the boiler under pressure, will be made at the discretion of the inspector.

d. Low pressure steam boilers must be inspected annually. Low pressure steam boilers of steel construction must be inspected alternately internally and externally. The issuance of a certificate must normally be based on the internal inspection.

~~c.~~ e. Hot water heating and hot water supply boilers must be inspected biennially unless they are located in a nursing home, school, nursery school, or kindergarten, in which case they must be inspected annually. Internal inspections will be required when deemed necessary by the inspector.

~~d.~~ f. A grace period of two months beyond the period specified in the above subdivisions may elapse between inspections.

2. The only reports normally required by the chief boiler inspector will be reports of inspections made as a certificate inspection. Certificate inspections must be made during the period of thirty days prior to and thirty days after the

expiration date of the certificate. Noncertificate inspections, when required by the provisions of this section, must be documented in such a manner that reports of these inspections may be furnished to the state insurance department upon the request of the chief boiler inspector. The chief boiler inspector encourages reports to be made at any time adverse conditions are found, or when difficulty is encountered getting cooperation from the owner or user.

3. The inspections required under this section must be made by the chief boiler inspector, or by a deputy inspector, or by a special inspector provided for in this article.

4. If at any time a hydrostatic test is deemed necessary by the inspector, it must be made by the owner or user in the presence of, and under the supervision of the inspector, and must be approved by the inspector.

5. Cast iron boilers must be considered as boilers that do not lend themselves to internal inspections. Internal inspections of electric boilers must be made when deemed necessary by the inspector.

History: Effective June 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

45-12-04-05. Safety valve capacity. The minimum required relieving capacity of safety valves or safety relief valves for all types of boilers may not be less than the maximum designed steaming capacity as determined by the manufacturer and must be based on the capacity of all the fuel burning equipment as limited by other boiler functions.

History: Effective April 1, 1996.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

CHAPTER 45-12-10

45-12-10-01. Construction and installation standards - Exceptions. Unfired pressure vessels may not be installed in North Dakota unless such vessels have been constructed in accordance with the American Society of Mechanical Engineers Boiler and Pressure Vessel Code, section VIII, division 1 or 2, and bear the "U" stamp as proof of such construction.

Manufacturers shall register unfired pressure vessels with the national board of boiler and pressure vessel inspectors. Unfired pressure vessels must bear the required stamping of the national board.

The requirements of this section apply to all pressure vessels within the scope of the American Society of Mechanical Engineers Code, section VIII, divisions 1 and 2, ~~1992~~ 1995 edition with these exceptions:

1. Pressure vessels under federal control.
2. Pressure vessels that do not exceed four cubic feet [thirty United States gallons] in volume and two hundred fifty pounds per square inch gauge [1723.70 kilopascals] in pressure.
3. Pressure vessels that do not exceed one and one-half cubic feet [11.22 United States gallons] in volume and six hundred pounds per square inch gauge [4136.88 kilopascals] in pressure.
4. Unfired pressure vessels installed or ordered prior to November 1, 1987. However, these unfired pressure vessels must be maintained in a safe operating condition using ANSI/NB-23 and ANSI/API-510 as guidelines.

Unfired pressure vessels referenced by this section must be protected with the American society of mechanical engineers stamped pressure relief devices as defined in section VIII of the American Society of Mechanical Engineers Code.

Existing pressure relief devices installed on unfired pressure vessels referenced by this section will be considered acceptable if the pressure relief device is set for the correct pressure, if the usage is correct, and if the device is in a satisfactory operation condition.

History: Effective June 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

45-12-10-02. Application of standards - Repairs.

1. These rules apply only to new construction, except as noted below:

   a. Reinstalled pressure vessels must meet the rules for new construction. Exception: National board registration is required only for those vessels ordered and constructed after November 1, 1987.

   b. Repairs to unfired pressure vessels and to safety and safety relief valves for those vessels:

      (1) Repairs to safety valves and safety relief valves must be such that valve function is not impaired and the repaired valve will perform to the standards for which it was originally constructed. It is recommended that these repairs be made by a firm in possession of a valid "VR" certificate of authorization from the national board of boiler and pressure vessel inspectors.

      (2) Repairs to unfired pressure vessels must be such that vessels repaired will be returned to a safe and satisfactory operating condition, provided there is not deviation from the original design. It is recommended that these repairs be made by a firm in possession of a valid "R" certificate of authorization from the national board of boiler and pressure vessel inspectors.

      (3) The National Board Inspection Code (ANSI/NB-23, ~~1992~~ 1995 edition) and the American Petroleum Institute Code (ANSI/API-510, 1992 edition) cover repair and alteration procedures. ANSI/API-510 may be used to cover the maintenance inspection, repair, alteration, and rerating procedure for pressure vessels used by the petroleum and chemical process industries. It is intended that ANSI/NB-23 cover installations other than those covered by ANSI/API-510.

   c. Alterations to unfired pressure vessels:

      (1) Alterations, as defined in ANSI/NB-23, must be made by a national board "R" certificate holder.

      (2) Alterations may also be made by an organization operating under the provisions of ANSI/API-510, provided the alteration is within the scope of ANSI/API-510.

History: Effective June 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 26.1-22.1-14
Law Implemented: NDCC 26.1-22.1-14

TITLE 48

Board of Animal Health

APRIL 1996

CHAPTER 48-04-02

48-04-02-01. Exception to notice requirements upon sale or gift. ~~When cattle have been positively diagnosed as being infected with paratuberculosis (Johne's disease), by a test recognized and approved by the state veterinarian, and the diagnosis is known to the owner, agent, or other person having charge of the infected animal, the~~ The provisions of North Dakota Century Code section 36-14-01 do not apply~~, if the owner, agent, or other person having charge of the infected animals complies with the provisions of section 48-04-02-02~~ to cattle suspected of being infected with, or exposed to, paratuberculosis (Johne's disease).

History: Effective March 1, 1988; amended effective April 1, 1996.
General Authority: NDCC 36-01-08
Law Implemented: NDCC 36-01-12, 36-14-01

48-04-02-02. Procedure required upon paratuberculosis diagnosis. ~~Upon positive diagnosis of paratuberculosis as required in section 48-04-02-01, the owner, agent, or other person having charge of any animal so infected, shall proceed as follows:~~

~~1. The infected animal must be identified, isolated, and sent to slaughter within fifteen days from the time of paratuberculosis diagnosis.~~

~~2. For the remainder of the herd of which the infected animal was a part, the owner, agent, or other person having charge of the herd shall submit all of the animals of the herd over two years of age to a paratuberculosis test recognized and approved by the state veterinarian. If any animals from the~~

~~remainder of the herd are diagnosed positive, they must be identified, isolated, and sent to slaughter. Animals diagnosed as negative require no further testing. Any animals diagnosed in the suspect range, upon which a final determination cannot be made, require no further testing, but the owner, agent, or other person having charge of the herd may request a second test. If a second paratuberculosis test is administered, any animals diagnosed positive must be identified, isolated, and sent to slaughter, and any animals diagnosed as negative require no further testing. After removal of all animals tested and diagnosed positive from the herd pursuant to an approved test procedure, the status of the remainder of the herd will be unaffected, and there shall be no requirement, upon sale or gift, that due notice of paratuberculosis or suspicion of paratuberculosis be given to any person.~~ Repealed effective April 1, 1996.

~~History: Effective March 1, 1988.~~
General Authority: ~~NDCC 36-01-08~~
Law Implemented: ~~NDCC 36-01-12, 36-14-01~~

TITLE 50

Medical Examiners, Board of

APRIL 1996

CHAPTER 50-02-05

50-02-05-01. Standard certificate from educational commission required. All applicants for licensure who are graduates of foreign medical schools, except the medical schools of Canada, the United Kingdom, Australia, and New Zealand, are required to present the standard certificate from the educational commission for foreign medical graduates with an examination grade of seventy-five or better as a prerequisite for admission to the North Dakota medical board examinations. This requirement shall not apply to applicants who were first licensed to practice medicine in the United States prior to the availability of the educational commission for foreign medical graduates examination.

History: Amended effective April 1, 1996.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 43-17-18

50-02-05-02. Requirements for licensure by reciprocity or endorsement. Graduates of ~~foreign~~ medical schools not located within the United States or Canada who have a license from another state will not be licensed in North Dakota by either reciprocity or endorsement unless licensure was secured by passing the federation licensing examination, or the United States medical licensing examination (USMLE), and the candidate has fulfilled other North Dakota licensure requirements. However, those applicants seeking licensure by either reciprocity or endorsement who passed a written examination in another state before the advent of the federation licensing examination may be considered on an individual basis. Those candidates may also be

be required to pass the special purpose examination (SPEX) administered by the federation of state medical boards of the United States.

History: Amended effective December 1, 1988; November 1, 1995; April 1, 1996.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 43-17-21

CHAPTER 50-03-01

50-03-01-03. Supervision contract requirements. Upon undertaking the supervision of a physician assistant as contemplated by this chapter, the physician shall file with the board a copy of the contract ~~showing a list of the specific tasks that the physician contemplates may be assigned to the physician assistant~~ establishing that relationship. That contract ~~and list of tasks~~ must be approved by the board of medical examiners.

The contract must be confirmed annually by completing and filing with the board such forms as are requested and provided by the board. The board must be notified within seventy-two hours of any contract termination or modification.

Every physician who supervises a physician assistant under this chapter must practice medicine in North Dakota. No physician may act as a supervising physician for any physician assistant who is that physician's spouse or a member of the physician's immediate family unless specific authorization for such supervision has been approved by the board of medical examiners.

History: Amended effective July 1, 1988; July 1, 1994; April 1, 1996.
General Authority: NDCC ~~43-17-13~~ 28-32-02
Law Implemented: NDCC 43-17-02(10)

50-03-01-06. Assistant's functions limited. ~~The physician assistant shall function only in those areas of medical practice where the supervising physician provides care for the physician's patients.~~ Physician assistants may perform only those duties and responsibilities that are delegated by their supervising physicians. No supervising physician may delegate to a physician assistant any duty or responsibility for which the physician assistant has not been adequately trained. Physician assistants are the agents of their supervising physicians in the performance of all practice-related activities. A physician assistant may provide patient care only in those areas of medical practice where the supervising physician provides patient care.

History: Amended effective July 1, 1988; November 1, 1993; July 1, 1994; April 1, 1996.
General Authority: NDCC 43-17-13
Law Implemented: NDCC 43-17-02(10)

50-03-01-11. Revocation of registration. The board may deny, suspend, or revoke registration of a physician assistant upon any of the following grounds:

1. Failing to demonstrate the qualifications for registration under this act or the regulations of the board.

2. Soliciting or receiving any form of compensation from any person other than the assistant's registered employer for services performed as a physician assistant.

3. Willfully or negligently divulging a professional confidence or discussing a patient's condition or a physician's diagnosis without the express permission of the physician.

4. The habitual or excessive use of intoxicants or drugs.

5. Aiding or abetting the practice of medicine by a person not licensed by the board.

6. Gross negligence in performing the duties, tasks, or functions assigned to the assistant by ~~the employer physician~~ a supervising physician.

7. Manifest incapacity or incompetence to perform as a physician assistant.

8. Conduct unbecoming in a person registered as a physician assistant or detrimental to the best interests of the public or the profession.

9. Repeated or willful violation of the contract of employment on file with the board.

10. Representing himself or herself to be a physician.

11. Fraud or deceit in obtaining initial registration as a physician assistant, the renewal of registration as a physician assistant, or in the practice of the physician assistant profession.

History: Amended effective July 1, 1988; November 1, 1993; April 1, 1996.
General Authority: NDCC 43-17-13
Law Implemented: NDCC 43-17-02(10)

TITLE 54

Nursing, Board of

MAY 1996

CHAPTER 54-02-01

54-02-01-05. Examination results. Examination results will be reported by mail to individual candidates and recorded on the candidate's permanent record in the board office. The examination results for the successful candidate will include the number of the permanent license that shall be issued to the candidate ~~and a notice that these results constitute permission to continue in the practice of nursing until the permanent license has been issued~~.

History: Amended effective November 1, 1979; October 1, 1989; December 1, 1991; January 1, 1994; May 1, 1996.
General Authority: NDCC ~~43-12.1-08(18)~~ 43-12.1-08(5)
Law Implemented: NDCC ~~43-12.1-10~~ 43-12.1-09(1)

54-02-01-08. Employment verification. ~~For all candidates not residing in North Dakota, a verification of employment form issued by the board must be signed by the North Dakota employer or potential employer before authorization to practice is issued.~~ Repealed effective May 1, 1996.

History: ~~Amended effective October 1, 1989.~~
General Authority: ~~NDCC 43-12.1-08(18)~~
Law Implemented: ~~NDCC 43-12.1-11~~

54-02-01-13. Authorization to practice nursing. Authorization to practice nursing between the dates of program completion and notification of results of the licensing examination will be issued to individuals accepted as candidates for the first licensing examination

after program completion for which the candidate is eligible. Eligibility will be determined by the following criteria:

1. The applicant has submitted a completed application, the appropriate fee, and official transcript verifying program completion to the board office.

2. ~~The--applicant--is--a--North--Dakota--resident-or-has-accepted employment-in-North-Dakota-or-the-federal-government;~~

3. The applicant's registration with the testing center has been reported to the board office.

Upon receipt of the work authorization, the applicant may use the appropriate title of graduate nurse or graduate practical nurse or the appropriate abbreviation of "G.N." or "G.P.N.". The applicant must practice under the supervision of a registered nurse while the authorization to practice is valid. The work authorization to practice will expire in ~~sixty~~ ninety days or upon notification of the testing results, whichever occurs first. The work authorization is nonrenewable and available only to graduates who complete application for licensure within sixty days of graduation.

History: Effective October 1, 1989; amended effective December 1, 1991; January 1, 1994; May 1, 1996.
General Authority: NDCC ~~43-12.1-08(18)~~ 43-12.1-08
Law Implemented: NDCC ~~43-12.1-10~~ 43-12.1-09(1)

54-02-02-09. Maximum number of attempts to write the licensing examination. Candidates will have a maximum number of five attempts to pass the licensing examination. The candidate must have completed the nursing education program within ~~five~~ three years of the scheduled appointment to write the examination.

History: Effective January 1, 1994; amended effective May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-10~~ 43-12.1-08(5)

CHAPTER 54-02-05

54-02-05-01. Residency or employment requirement. Any applicant for renewal of license must be a North Dakota resident or practicing nursing in North Dakota or with ~~the~~ a federal ~~government~~ agency.

History: Amended effective November 1, 1990; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-13~~ 43-12.1-10

54-02-05-05. Nonpracticing nurses. Any nurse who has not actively practiced nursing in North Dakota for five years or more must meet the following requirements before a license to practice is issued:

1. Complete the relicensure application.
2. Pay the current renewal fee.
3. Provide the board with proof of one of the following:
   a. Practice as a registered nurse or licensed practical nurse within the preceding five years in another state, territory, or country. Verification of employment is to be submitted.
   b. Completion of a refresher course in nursing, in accordance with board guidelines, within the preceding year.
   c. ~~Enrollment~~ Proof of progression in a board-recognized nursing program to further their education in nursing.
   d. Other evidence the licensee wishes to submit which would provide proof of nursing competence.

History: Amended effective June 1, 1982; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-08(13)~~ 43-12.1-08(9)

54-02-05-05.1. Practice requirements for license renewal. Nursing practice for purposes of relicensure must meet or exceed five hundred hours within the preceding five years. Nursing ~~practice~~ is defined in ~~subsections 5 and~~ subsection 6 of North Dakota Century Code section 43-12.1-02. Hours practiced in another regulated profession cannot be used for nursing practice hours.

History: Effective July 1, 1987; amended effective November 1, 1990; September 1, 1994; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-08(13)~~ 43-12.1-08(9)

54-02-05-07. Encumbered license. A license that is encumbered by specific practice restrictions shall be issued with the following statement: "This license is encumbered. Please contact the board office." If a licensee has ~~both~~ a registered nurse ~~license~~ and an advanced practice registered nurse license, the encumbrance ~~must be on~~ applies to both ~~licenses~~ practices.

History: Effective March 1, 1986; amended effective March 1, 1992; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-14

CHAPTER 54-02-06

54-02-06-01. Application and fee for license by endorsement. Applicants for license by endorsement must submit a completed notarized application and pay the endorsement fee of seventy-five dollars. Applicants for licensure by endorsement must have completed a state-approved nursing education program which meets or exceeds those requirements outlined in article 54-03 or 54-03.1 according to the date the applicant enrolled in the nursing education program. Nursing practice to demonstrate continued competency must meet or exceed five hundred hours within the preceding five years.

History: Amended effective November 1, 1979; March 1, 1986; March 1, 1992; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-12~~ 43-12.1-09(2)

54-02-06-01.1. Temporary permit. Upon receipt of the application for license by endorsement, payment of the fee as set by the board, and evidence that an applicant will meet all the requirements for licensure in North Dakota, the board may issue a temporary permit to practice as a registered nurse or licensed practical nurse in this state until the license is issued. The temporary permit expires at the end of ninety days and may be renewed only for reasons satisfactory to the board.

History: Effective May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(5)(8)

CHAPTER 54-05-01

54-05-01-01. Statement of intent. ~~The role of the licensed practical nurse in health care is to give holistic nursing care to clients in nursing practice settings under the direction of the registered nurse, licensed physician, or dentist. The knowledge, skills, and abilities of the licensed practical nurse are based on the nurse's educational preparation and nursing experience.~~

Each licensed practical nurse is responsible and accountable to practice according to the standards of practice prescribed by the board and the profession. ~~The licensed practical nurse is responsible and accountable for the care provided and assuring the safety and well-being of the clients and significant others. The licensed practical nurse's acceptance of assigned nursing responsibilities must be based upon client care needs, the knowledge, skills, and abilities of the practical nurse, and agency policy. The nursing care remains the responsibility of both the delegator and the licensed practical nurse.~~ The purpose of the standards is to:

1. Establish acceptable levels of nursing practice for the licensed practical nurse.

2. Serve as a guide for the board to evaluate the practice of the licensed practical nurse to determine if the practice is safe and effective.

History: Effective June 1, 1979; amended effective January 1, 1994; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-~~12.1-08(15)~~ 43-12.1-08(6)

54-05-01-02. ~~Standards of practice~~ Licensed practical nurse's contribution to, and responsibility for, the nursing process. The licensed practical nurse assists in implementing the nursing process. The components of the nursing process are assessment, planning, implementation, and evaluation. ~~Written and verbal communication is essential to the nursing process.~~ The licensed practical nurse under the direction of the registered nurse, advanced practice registered nurse, or licensed physician, will:

1. ~~Collect relevant health care data~~ Contribute to the nursing assessment by collecting, reporting, and recording objective and subjective data in an accurate and timely manner.

2. ~~Organize data and contribute to the development of an individualized nursing plan of care based upon the nursing diagnosis~~ Participate in the development of a nursing plan of care in consultation with other nursing and other health care personnel.

3. ~~Implement--the--individualized-nursing-plan-of-care-to-achieve the-expected-outcomes.~~ Provide nursing care by:

   a. Caring for clients whose conditions are stable or predictable;

   b. Assisting with clients whose conditions are critical or unpredictable;

   c. Implementing nursing care according to the priority of needs and established practices;

   d. Providing an environment conducive to safety and health;

   e. Documenting nursing interventions and responses to care; and

   f. Communicating nursing interventions and responses to care to appropriate members of the health care team.

4. Delegate or assign components of nursing care to other members of the nursing care team.

5. Collaborate in the evaluation of the client's response toward the achievement of the expected outcomes.

History: Effective June 1, 1979; amended effective January 1, 1994; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-08(15)~~ 43-12.1-08(6)

54-05-01-03. ~~Role--of--the--licensed~~ Licensed **practical nurse** responsibilities as a member of the health care team. The licensed practical nurse is responsible and accountable for the care provided and assuring the safety and well-being of the clients. The licensed practical nurse's acceptance of assigned nursing responsibilities must be based upon client care needs; the knowledge, skills, and abilities of the practical nurse; and agency policy. The licensed practical nurse under the direction of the registered nurse, advanced practice registered nurse, or licensed physician~~,-or-dentist~~ will:

1. Involve the client and significant others in the client's health restoration, promotion, and maintenance.

2. Utilize established lines of authority and communication to provide care to clients ~~with-actual-or-potential-responses--to health-problems~~.

3. Participate in client teaching specific to the ~~actual-or potential~~ learning needs by implementing or modifying ~~standard~~ teaching plans.

4. Manage the environment and resources effectively and efficiently to ~~attain goals--specific--to~~ meet ~~clients--with actual--or--potential--responses--to-health~~ clients' needs and attain expected outcomes.

5. Recognize and utilize the current knowledge base of nursing practice ~~acquired-through-nursing-research~~.

6. Recognize ~~client~~ and protect clients' rights ~~and--seek appropriate-resources-to-protect-those-rights~~.

7. Practice within the ethical frameworks and standards of the nursing profession.

8. Evaluate own nursing practice in relation to professional nursing practice standards ~~and---relevant---statutes---and regulations~~.

9. Participate in quality improvement measures to evaluate and modify practice.

10. Demonstrate knowledge and understanding of the statutes and rules governing nursing and function within the legal boundaries of practical nursing practice.

11. Observe and follow the duly adopted standards, policies, directives, and orders of the board as they may relate to the licensed practical nurse.

12. ~~Acquire--and--maintain--current--knowledge-in-nursing-practice~~ Retain accountability for tasks delegated to other members of the nursing care team.

~~10.~~ 13. ~~Maximize--the--client's--health--care--through-the-appropriate delegation-of-nursing-tasks-and-nursing-functions-to-the-nurse assistant~~ Protect confidential information unless obligated by law to disclose the information.

History: Effective January 1, 1994; amended effective May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-08(15)~~ 43-12.1-08(6)

54-05-01-04. Criteria for delegation to licensed practical nurses. Delegation of nursing care to the licensed practical ~~nurses~~ nurse shall comply with the following criteria:

1. The responsibilities must be within the scope of practice delineated by the board and described within agency written policy.

2. The registered nurse, advanced practice registered nurse, or licensed physician~~,-or-dentist~~ must make:

a. Make an assessment of the client's nursing health care needs prior to delegating the responsibilities.;

2.--The--responsibilities--must--be--within--the-scope-of-practice delineated-by-the-board-and-described--within--agency--written policy.

3. b. The--delegating--registered--nurse,-licensed-physician,-or dentist-must-determine Determine the responsibilities that can be properly and safely performed by the licensed practical nurse.; and

4. c. The-registered-nurse,-licensed-physician,-or-dentist-shall supervise Supervise the performance and documentation of the delegated responsibilities by the licensed practical nurse.

5. 3. The nursing care provided remains the responsibility of both the delegator and the licensed practical nurse.

History: Effective January 1, 1994; amended effective May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(15) 43-12.1-08(6)

54-05-01-05. Criteria for delegation of specialized nursing care to the licensed practical nurse. The-licensed-practical-nurse-providing specialized--nursing--care-is-a-licensed-practical-nurse-with-additional preparation--and--experience--who--is--qualified---to---assume---greater responsibility--in-specialized-care-areas-or-in-patient-care-management, or-both,-according-to--designated--written--policies--of--the--employing institution.--The-registered-nurse,-licensed-physician,-or-dentist-shall determine--that--the--licensed--practical--nurse--providing--specialized nursing-care-meets-the-following-qualifications:

1.--Has--a-minimum-of-one-year's-experience-in-nursing-practice-at the-staff-level.

2.--Provides-verification-of-having-acquired-additional-knowledge, skills,--and--abilities--necessary--to--assume---the---greater responsibility-in-specialized-nursing-care-areas.

3.--Practices--according--to--the--employing--institution--written policies--that--address---the---licensed---practical---nurse's preparation-and-role-in-specialized-nursing-care.

4.--The--nursing--care--remains--the--responsibility--of--both-the delegator--and--the--licensed---practical---nurse. Repealed effective May 1, 1996.

History: Effective-January-1,-1994.
General Authority: NDCC-43-12.1-08
Law Implemented: NDCC-43-12.1-08(15)

54-05-01-06. Role of the licensed practical nurse in intravenous therapy. Selected components in the nursing management of intravenous therapy as defined by the board may be performed by a licensed practical nurse who has completed a board-approved associate degree program that includes intravenous therapy in the curriculum or one who has successfully completed a course in intravenous therapy which was developed according to board guidelines and approved by the board.

History: Effective May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(6)

CHAPTER 54-05-02

54-05-02-01. Statement of intent. ~~The practice of the registered nurse is determined by the educational program completed and the knowledge, technical skills, and process skills the nurse acquires to facilitate positive responses in the health status of the client. The registered nurse uses a variety of scientific principles to synthesize relevant information and make clinical inferences. The registered nurse applies nursing theory to the assessment, diagnosis, outcome criteria, planning, interventions, and evaluation of human responses in nursing practice settings to provide holistic nursing care.~~

~~The registered nurse in clinical practice functions as a direct caregiver in both institutional and community settings. In addition, the registered nurse functions as a client care manager, educator, researcher, and as case manager or coordinator of client care services within the broader health service system. Each function is to be carried out with consideration for optimum health care and client safety. The registered nurse is accountable for all nursing responsibilities the registered nurse accepts.~~

The registered nurse is responsible and accountable to practice according to the standards of practice prescribed by the board and the profession. Registered nurses established the ~~standards of~~ practice parameters for nursing care for all client populations in all practice settings. ~~The extent to which the standard will be met is relative to the nurse's academic preparation and experience.~~ The purpose of the standards is:

1. To establish acceptable levels of safe nursing practice for the registered nurse.
2. To serve as a guide for the board to evaluate the practice of the registered nurse to determine if the practice is safe and effective.

History: Effective June 1, 1979; amended effective March 1, 1986; January 1, 1994; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-08(15)~~ 43-12.1-08(6)

54-05-02-02. ~~Standards of practice~~ Registered nurse responsibility to implement the nursing process. The registered nurse utilizes the nursing process to assess, diagnose, establish a plan with outcome criteria, intervene, evaluate, and document human responses to actual or potential health problems in nursing practice settings. The registered nurse will:

1. ~~Collect--and--assess-relevant-health-data~~ Conduct and document nursing assessments of the health status of individuals, groups, and communities.

2. Analyze the ~~client~~ data base to establish and document the nursing diagnoses.

3. ~~Identify-expected-outcomes-individualized-to-the-client.~~

4. Develop a nursing plan of care based on assessment and nursing diagnosis that prescribes interventions to attain expected outcomes.

~~5.~~ 4. Implement the nursing plan of care~~.~~ by:

a. Writing nursing orders;

b. Giving direct care;

c. Assisting with care;

d. Delegating care;

e. Providing an environment conducive to safety and health;

f. Documenting nursing interventions; and

g. Communicating responses.

~~6.~~ 5. Evaluate the ~~client's~~ responses of individuals, groups, or communities toward ~~attainment~~ achievement of the expected outcomes and modify the nursing plan of care as indicated.

History: Effective June 1, 1979; amended effective January 1, 1994; May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-08(15)~~ 43-12.1-08(6)

54-05-02-03. ~~Role---of---the---registered~~ Registered **nurse** responsibilities as a member of the nursing profession. The registered nurse is responsible and accountable for the care provided and for assuring the safety and well-being of the client. The registered nurse functions as a member of a health care team by collaborating with the client and health care providers in providing client care. The registered nurse will:

1. Assist the client to maximize the client's health through the direct implementation of the nursing plan of care.

2. Maximize the client's health ~~through--the--appropriate delegation-of-components-of-the-nursing-plan-of-care.~~ by:

a. Delegating to another only those nursing activities which that person is prepared or qualified to perform;

b. Supervising others to whom nursing activities are delegated or assigned; and

c. Retaining professional accountability for nursing care when delegating nursing activities.

3. Facilitate communication between the client, significant others, and health care team.

4. Design and implement a teaching plan specific to the ~~actual or potential learning~~ needs of the client.

5. ~~Manage~~ Utilize resources, environments, and programs to maximize client outcomes.

6. Utilize research findings appropriate to nursing practice.

7. ~~Advocate for~~ Recognize and protect client rights.

8. Practice within the ethical frameworks and standards of the nursing profession.

9. Assume a leadership role in health care management.

10. Evaluate the nurse's own nursing practice in relation to professional practice standards ~~and relevant statutes and regulations~~.

11. ~~Acquire and maintain current knowledge in nursing practice~~ Participate in a quality improvement measures to evaluate and modify practice.

12. Demonstrate knowledge and understanding of the statutes and rules governing nursing and function within the legal boundaries of registered nursing practice.

13. Observe and follow the duly adopted standards, policies, directives, and orders of the board as they may relate to the registered nurse.

~~12.~~ 14. ~~Participate in quality of care activities as appropriate to position, education, and practice environment~~ Protect confidential information unless obligated by law to disclose the information.

~~13. Collaborate with the client, significant others, and health care providers in providing client care.~~

~~14.~~ 15. Contribute to the professional development of peers, colleagues, and others.

History: Effective January 1, 1994; amended effective May 1, 1996.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC ~~43-12.1-08(15)~~ 43-12.1-08(6)

TITLE 55

Nursing Home Administrators, Board of Examiners for

JUNE 1996

CHAPTER 55-02-01

55-02-01-03. Board meetings. The board shall meet twice annually. The chairperson, or other presiding officer of the board, may call ~~special~~ additional meetings ~~thereof--when,-in-the-chairperson's judgment,~~ at any time the circumstances or functioning of the board require it.

History: Amended effective June 1, 1996.
General Authority: NDCC 43-34-09
Law Implemented: NDCC 43-34-09

55-02-01-05. Duties of board of officers.

1. The chairperson shall preside at all meetings of the board, and shall sign all official documents of the board.

2. In the absence of the chairperson, the vice chairperson shall preside at meetings, and perform all duties usually performed by the chairperson.

3. The secretary-treasurer ~~is-responsible-for-keeping~~ shall keep a full and complete record of the minutes of the meetings, ~~maintaining--the~~ maintain records pertaining to licensees and registrants ~~and-this-title~~, and ~~maintaining--such~~ maintain financial records ~~as-are~~ approved by the board and the fiscal authorities of the state.

History: Amended effective February 1, 1993; June 1, 1996.
General Authority: NDCC 43-34-07, 43-34-09
Law Implemented: NDCC 43-34-07, 43-34-09

55-02-01-07. Requirements for licensure. No person~~,-except-an individual-applying-for-license-through-endorsement,~~ shall be admitted ~~to--or--be~~ permitted to take an examination for ~~license~~ licensure as a nursing home administrator unless the person shall have first submitted evidence satisfactory to the board that the person:

1. ~~Has-had-at-least-three-years'-experience-as-a-licensed-nursing home-administrator;-or~~

2~~.~~ Has a baccalaureate degree in long-term care administration from an accredited college or university or has a baccalaureate degree from an accredited college or university with a minimum of one course in each of the following: management, finance, human resources, and gerontology; and

2. If making application for an examination occurring on or after July 1, 1997, has completed a board-approved administrator-in-training program.

History: Amended effective July 1, 1979; February 1, 1993; June 1, 1996.
General Authority: NDCC 43-34-08
Law Implemented: NDCC 43-34-03

55-02-01-08. Application for examination. An applicant for examination and qualification for a-~~license~~ licensure as a nursing home administrator shall make application in writing, on forms provided by the board, and shall furnish evidence satisfactory to the board that the applicant ~~has--met~~ meets the licensure requirements as provided for in section 55-02-01-07. An applicant for examination shall submit two references from individuals engaged in business, professional, or religious work, who shall speak, at a minimum, to the applicant's educational preparation or experience related to long-term care administration.

History: Amended effective February 1, 1993; June 1, 1996.
General Authority: NDCC 43-34-09
Law Implemented: NDCC 43-34-03

55-02-01-10. Examination.

1. Every applicant for a--~~license~~ licensure as a nursing home administrator, except an individual applying for licensure through endorsement, ~~must~~ shall be required to pass an-~~oral examination--and~~ a written national examination and if application is made on or before January 10, 1997, an oral examination.

2. The board shall use as a basis for ~~the~~ an oral examination a written outline of the subject matter ~~which~~ that may include:

a. Applicable standards of environmental health and safety;

b. Local health and safety regulations;

c. General administration;

d. Psychology of patient care;

e. Principles of medical care;

f. Personal and social care;

g. Therapeutic and supportive care and services in long-term care;

h. Departmental organization and management; and

i. Community interrelationships.

3. The board shall use the test provided by the national association of boards of examiners for nursing home administrators for the written examination.

History: Amended effective February 1, 1993; June 1, 1996.
General Authority: NDCC 43-34-09
Law Implemented: NDCC 43-34-03

55-02-01-11. Grading examinations.

1. Grading must be pass or fail for ~~the~~ an oral examination.

2. The national scale score ~~will~~ shall be used to determine a passing point for the written examination.

History: Amended effective July 1, 1981; June 1, 1983; February 1, 1993; June 1, 1996.
General Authority: NDCC 43-34-09
Law Implemented: NDCC 43-34-09

55-02-01-15. Licenses.

1. An applicant for a ~~license~~ licensure as a nursing home administrator who has successfully complied with the requirements of North Dakota Century Code chapter 43-34 and this ~~article~~ chapter and has passed the examinations provided ~~for--by--the--board~~ in section 55-02-01-10 shall be issued a license ~~on-a-form-provided-for--that--purpose--by--the--board,~~ certifying that ~~such~~ the applicant has met the requirements of the laws and rules entitling the applicant to serve, act, practice, and otherwise hold oneself out as a duly licensed nursing home administrator.

2. The board may, upon application, issue a provisional license to any ~~individual~~ person who:

   a. Meets the requirements for ~~examination~~ licensure set forth in section 55-02-01-07;

   b. Has a bona fide offered position as a nursing home administrator;

   c. ~~Passes--an--oral--examination~~ If applying on or before January 10, 1997, passes an oral examination; and

   d. Has never previously held a provisional license in North Dakota.

3. The provisional license is valid until the results of the next scheduled written examination are received by the board.

4. Upon application, the board may issue a license through endorsement to any person who:

   a. Has received a passing grade on a national exam recognized by the national association of boards of examiners for nursing home administrators;

   b. Pays an application fee;

   c. Holds a valid license from the transferring state; and

   d. Either satisfies the licensure requirements under section 55-02-01-07 or has been employed as a licensed nursing home administrator for at least thirty-six months of forty-eight months immediately preceding the application.

History: Amended effective February 1, 1993; June 1, 1996.
General Authority: NDCC 43-34-09
Law Implemented: NDCC 43-34-04

55-02-01-16. Registration and renewal of licenses.

1. ~~Every~~ Any person who holds a ~~valid~~ license ~~as-a-nursing-home administrator~~ issued by the board shall ~~immediately--upon issuance--thereof~~ be ~~deemed~~ registered with the board. The license shall expire on the thirty-first day of December in the year of its issuance, and shall be renewable annually upon payment of the license fee. The board, by November fifteenth of each year, ~~will~~ shall transmit application for renewal forms to all licensees whose licenses ~~will~~ expire on December thirty-first.

2. Upon making an application for a renewal ~~of-license~~, the licensee shall pay an annual license fee not to exceed the

amount set forth in North Dakota Century Code section 43-34-05.

3. Upon receipt of the application for renewal, documentation of the continuing education hours required in section 55-02-01-12 and the license fee, the board shall issue a renewal license to the nursing home administrator.

4. The board shall maintain a register of all applications for licensing of nursing home administrators. The board shall maintain a complete file of such pertinent information as may be deemed necessary.

History: Amended effective February 1, 1993; June 1, 1996.
General Authority: NDCC 43-34-09, 43-34-10
Law Implemented: NDCC 43-34-09, 43-34-10

55-02-01-20. Endorsement. ~~For--endorsement-purposes,-the-board will-accept-a-passing-grade-of-the--national--board--of--examiners.---In addition--the--applicant--for--endorsement--must--pay--an-applicant-fee, satisfy-the-current-education-requirement,-pass-an-oral-examination,-and hold--a--currently--valid-license-from-the-transferring-state.~~ Repealed effective June 1, 1996.

History: ~~Amended-effective-February-1,-1993.~~
General Authority: ~~NDCC-43-34-09~~
Law Implemented: ~~NDCC-43-34-12~~

55-02-01-21. Inactive license status. A nursing home administrator whose license has not been revoked or suspended may request inactive license status. While in inactive license status, the administrator must submit a renewal application and a license fee annually but the continuing education requirement as set forth in section 55-02-01-12 need not be met. A license ~~will~~ may not be issued during the inactive license status period. A nursing home administrator must obtain twenty-five hours of continuing education hours prior to reactivating his or her license. ~~An~~ A nursing home administrator who chooses inactive license status for a period in excess of five consecutive years must pass an oral examination prior to reactivating a license.

History: Amended effective February 1, 1993; June 1, 1996.
General Authority: NDCC 43-34-03, 43-34-09
Law Implemented: NDCC 43-34-03, 43-34-09

55-02-01-24. Applicability - Legal effect - Separability.

1. This ~~article~~ chapter shall be supplemental to the law providing for the licensing of nursing home administrators and

pursuant to North Dakota Century Code section 28-32-03 shall have the force and effect of law.

2. Every rule, regulation, order, and direction adopted by the board shall state the date on which it takes effect and a copy thereof signed by the chairperson of the board and the secretary-treasurer of the board shall be filed as a public record in the office of the board and in accordance with requirements in North Dakota Century Code chapter 28-32.

3. This ~~article~~ chapter is intended to be consistent with the applicable federal and state law and shall be construed, whenever necessary, to achieve such consistency.

4. In the event that any provision of this ~~article~~ chapter is declared unconstitutional or invalid, or the application thereof to any person or circumstance is held invalid, the applicability of ~~such~~ the provision to other persons and circumstances and the constitutionality or validity of every other provision of this ~~article~~ chapter shall not be affected thereby.

5. This ~~article~~ chapter shall not affect pending actions or proceedings, civil or criminal, but the same may be prosecuted or defended in the same manner and with the same effect as though this ~~article~~ chapter has not been promulgated.

6. The board shall furnish ~~certified copies~~ a copy of this ~~title~~ chapter to all applicants and licensees.

7. Amendments to this ~~article shall~~ chapter may be made only ~~at a regularly called meeting of the board,~~ by a majority vote of all members of the board. ~~No amendment shall be acted upon unless the amendment was presented at a prior meeting and unless notice has been given to the members of the board that the amendment is to be acted upon at a particular meeting of the board.~~

History: Amended effective June 1, 1996.
General Authority: NDCC 28-32-03
Law Implemented: NDCC 43-34-09

TITLE 60

Pesticide Control Board

MARCH 1996

CHAPTER 60-03-01

60-03-01-05. Certification - Commercial applicators, dealers, private applicators.

1. **Categories of certification.**

   a. Agricultural pest control (plant and animal). This category includes commercial applicators using restricted use pesticides in production of agricultural crops including cereal grain, feed grains, soybeans, forages, large and small seeded legumes, small fruits, tree fruits, nuts, and vegetables, as well as application to grasslands and noncrop lands. This also includes the use of restricted use pesticides on animals, beef cattle, dairy cattle, swine, sheep, horses, goats, poultry, and other livestock, and also to places on or in which animals are confined.

   b. Seed treatment. This category includes commercial applicators using restricted use pesticides on agricultural crop seeds, other seeds, and vegetative seed stocks.

   c. Fumigation. This category includes applicators using restricted use fumigants for controlling pests in stored and transported agricultural crops, grain milling equipment, and storage facilities. (Effective April 1, 1991, private applicators.)

   d. Ornamental and turf pest control. This category includes commercial applicators using restricted use pesticides to

control pests in the production and maintenance of ornamental trees, shrubs, flowers, and turf.

e. Greenhouse. This category includes commercial applicators using restricted use pesticides to control pests in a greenhouse.

f. Right of way. This category includes commercial applicators using restricted use pesticides to control pests in the maintenance of public roads, electric powerlines, pipelines, railways, right of ways, parking lots, or other similar areas.

g. Public health pest control. This category includes state, federal, or other government employees, or applicators working under government contract, using restricted use pesticides in public health programs for the management and control of pests having medical and public health impacts.

h. Research and demonstration pest control. This category is for those individuals who demonstrate or apply restricted use pesticides for education and research or education or research. These would include county agents, extension specialists, state, federal, and commercial employees, plus other persons conducting research or demonstrating the proper application of restricted use pesticides.

i. Home, industrial, and institutional pest control. This category includes commercial applicators using restricted use pesticides in, on, or around food handling establishments, human dwellings, public or private institutions, warehouses, grain elevators, and any other structures or adjacent area, for the control of pests.

j. Wood preservatives. This category includes commercial applicators who apply and treat with restricted use wood preservatives to preserve and protect wood, posts, and various lumber products from pests.

k. Vertebrate. This category includes commercial applicators who use restricted use pesticides for the control of certain pest vertebrate, such as rodents, certain predators, and bats.

l. Other. This is reserved for any future categories that may be required by the United States environmental protection agency or become necessary by order of the pesticide control board.

2. **Commercial applicators and dealers.**

a. A commercial applicator or dealer, or commercial applicator and dealer certificate shall be issued in accordance with North Dakota Century Code section 4-35-09 or 4-35-12 or sections 4-35-09 and 4-35-12 respectively, only to those persons who successfully complete the certification examination established by the board, and who pay the certification fee.

b. The board shall establish a certification examination which shall be administered by any North Dakota state university extension designate in accordance with North Dakota Century Code section 4-35-09 or 4-35-12 or sections 4-35-09 and 4-35-12. The examination shall be given by the North Dakota state university extension designate only to those persons who:

(1) Are eighteen years of age or older; and

(2) Complete a certificate application in such form as the board shall require.

c. Commercial applicator's or dealer or commercial applicator and dealer certificates shall expire on April first following the third anniversary of the year of certification or recertification. Every commercially certified person shall be recertified by an approved seminar or an approved examination at least every third year and must complete an approved examination at least every ninth year.

d. Any person who fails an examination may retake such examination after three or more days.

e. All commercial applicators must be certified in the proper category of application.

f. All dealers must be certified in the category of the labels' intended target site.

g. Situations where the pesticide is labeled for more than one of the certification target sites, the dealer only needs to be certified in one of the categories.

3. **Private applicators.**

a. A private applicator certification shall be issued in accordance with North Dakota Century Code section 4-35-14 only to those persons who:

(1) Are eighteen years of age or older; and

(2) Demonstrate competence in the application of pesticides as provided in subdivisions b, c, d, and e.

b. Persons purchasing, storing, or applying restricted use grain fumigants must be commercially trained and must pass a fumigation exam. At the option of the applicant upon successfully passing the exam, the certificate issued will be for either private or commercial application of restricted use fumigants. The fee for the private and commercial certification will be set by the North Dakota state university extension service.

c. Competence to apply restricted use pesticides shall be demonstrated by a showing of any one of the following to the North Dakota state university extension designate in the applicant's area:

(1) Attendance at an approved educational seminar, signing of a certificate of attendance, and passing an examination.

(2) Completion of a course of self-instruction and passing an examination at the North Dakota state university extension designate's office in the applicant's area.

(3) Completion of a take-home self-study program and passing an examination.

(4) Passing the dealer or commercial applicator certification examination and submitting the passing grade to the appropriate North Dakota state university extension designate.

d. Every private applicator shall be recertified ~~at least once every five years~~ by an approved seminar or an approved examination at least every third year and must complete an approved examination at least every ninth year.

e. Competence to apply a single restricted use pesticide by a person who cannot read shall be demonstrated by completion of a course of oral instruction and completion of a procedure to determine teaching-learning effectiveness to the North Dakota state university extension designate in the applicant's area. Such private applicator certification for a single restricted use pesticide shall be for no more than one year and the notation, "Restricted to" followed by the common name of the restricted use pesticide in bold lettering shall appear on the private applicator certificate.

f. In an emergency situation, competence to apply a single restricted use pesticide by a person shall be demonstrated by completion of a course of oral instruction and completion of a procedure to determine teaching-learning effectiveness to the North Dakota state university extension designate in the applicant's area. Such private applicator certification for a single restricted use pesticide shall expire sixty days from issuance and shall be issued to a person only once. The notation, "Restricted to" followed by the common name of the restricted use pesticide shall appear on the private applicator certificate in bold lettering.

History: Amended effective February 1, 1982; October 1, 1990; November 1, 1991; March 1, 1996.
General Authority: NDCC 4-35-06, 4-35-12
Law Implemented: NDCC 4-35-08, 4-35-09, 4-35-12, 4-35-14

60-03-01-06. Application, storage, transportation, and disposal of pesticides.

1. **Application.**

   a. All pesticides shall be used in accordance with the label.

   b. Pesticide applicators and persons assisting with an application shall follow all safety precautions as specified on the container label.

   c. All equipment used in pesticide application must be operationally sound and properly calibrated to prevent unreasonable adverse effects on the environment.

   d. All pesticides that require posting on the label and under the environmental protection agency worker protection standard must be posted according to the environmental protection agency worker protection standard. In addition, the pesticides from the following list must be posted by the farm operator or the farm operator's cooperating designee, which may include commercial applicators.

      (1) Methyl parathion.

      (2) Ethyl parathion.

      (3) Dyfonate post emergence foliar applications.

      (4) Furadan post emergence foliar applications to corn and, sorghum, and sunflowers.

(5) Di-syston post emergence foliar application to corn and sorghum.

Any pesticide applicator applying ~~posting-required~~ pesticides from this list for a farm operator is required to inform the farm operator within twenty-four hours in advance of the pesticide application, allowing the farm operator time to post the field before the application occurs. The farm operator is primarily responsible for posting the field. However, if the applicator does not contact the farm operator before the application, the applicator is responsible for posting the field. Pesticide applicators are responsible to inform farm operators if applications do not occur as scheduled.

There are two options for properly posting fields.

Option 1: The signs must be a minimum of eight inches by eleven inches [20.32 centimeters by 27.94 centimeters] with one-half-inch [1.270-centimeter] lettering and be easily readable. The signs must be posted at all normal entrances to the field and on all corners which are along normally traveled roads. These signs can be a maximum of one-half mile [.80 kilometer] apart. The signs must contain the following information: Danger - field sprayed with (pesticide name). The field is safe for reentry on (date).

Option 2: Flags used by aerial applicators when marking field areas that have been sprayed can be used for posting. Such flags must be at least four inches by eight feet [10.16 centimeters by 2.438 meters]. The lettering on the flags must be fluorescent with a white background and must be easily readable. The signs must be dropped outside the field boundaries within fifty feet [15.24 meters] of all normal entrances to the field and all corners along normally traveled roads. These signs can be a maximum of one-fourth mile [.402 kilometer] apart along normally traveled roads. The signs must contain the following language: DANGER - KEEP OUT - THIS FIELD SPRAYED WITH A PESTICIDE. BEFORE ENTRY, CONTACT (business name and phone number).

The business name and phone number can be printed on the flag or, if the flag gives directions to refer to the attached cardboard, the business name and phone number can be printed on the cardboard.

Along with the lettering a skull and crossbones must be printed on the flag in a larger size than the largest lettering. The lettering for "Danger - Keep Out" must be at least three-fourths of an inch [1.905 centimeters].

The lettering for the remaining wording must be at least three-eighths of an inch [.953 centimeter].

2. **Storage.**

   a. All pesticides, except bulk pesticides, shall be stored in their original container and in accordance with label recommendations. All labels of stored pesticides shall be plainly visible. All pesticide containers must have a proper label affixed to them.

   b. All pesticides shall be stored in dry, well-ventilated spaces, and in a manner which will not endanger humans, animals, or the environment, nor contaminate food or feed.

   c. If a storage area contains a floor drain, it must be sealed or self-contained.

3. **Transportation.**

   a. All pesticides, except bulk pesticides, shall be transported in their original containers. All pesticides must be transported in a secure manner to avoid breakage of containers, spills, or any other manner of contamination.

   b. Pesticides shall not be transported with foodstuffs, feed, or any other product or material so as to pose a hazard to humans, animals, or the environment.

   c. Equipment contaminated in the transportation of pesticides shall be cleaned and decontaminated prior to any other use.

4. **Disposal.**

   a. Empty pesticide containers shall be stored in accordance with label recommendations and in a manner which will not endanger humans, animals, or the environment.

   b. Empty nonreturnable pesticide containers shall be triple-rinsed or equivalent. Secondary use of such containers which would endanger humans, animals, or the environment is prohibited.

   c. Pesticide containers shall be disposed of in accordance with label directions and in a manner which will not endanger humans, animals, or the environment.

History: Amended effective April 15, 1985; October 1, 1990; July 1, 1992; May 1, 1994; March 1, 1996.
General Authority: NDCC 4-35-06
Law Implemented: NDCC 4-35-06, 4-35-20

60-03-01-07. Recordkeeping - Dealers and commercial and custom applicators and private applicators.

1. **Dealers.** Every pesticide dealer shall keep separate, accurate, and complete ~~record~~ records of all purchases and sales of section 18 pesticides and restricted use pesticides. The ~~record~~ records shall include the following for each pesticide purchased or sold:

   a. Purchases.

      (1) Dealer's name and address.

      (2) Pesticide name.

      (3) Volume of pesticide.

      (4) Date pesticide was shipped or received.

      (5) Distributor's name (person from whom the pesticide was received).

   b. Sales.

      (1) Dealer's name and address and identification of person making the sale.

      (2) Name, address, certification number, and signature of private or commercial applicator.

      (3) Date of sale.

      (4) Trade name or common name and quantity of pesticide sold.

      (5) Running inventory by product.

      (6) Intended application site of purchaser for all section 18 pesticides.

2. **Commercial and custom applicators.** Commercial and custom applicators shall keep a record of all pesticide applications. A copy of the records must be provided to the client or the applicator must have on file a signed letter giving the applicator permission to keep the records for the client. The record shall include for each application:

   a. Name and address of the person for whom the pesticide was applied.

   b. Legal description of the land grain bin identification, railcar number, or other description of where the pesticide was applied.

c. Pest or pests controlled.

d. Time the pesticide was applied (month, day, year, hour of the day).

e. Person who supplied the pesticide which was applied.

f. Specific trade name of the pesticide applied and environmental protection agency registration number of the restricted used pesticide that was applied.

g. Direction and estimated velocity of the wind and the estimated temperature of the outdoor air at the time the pesticide was applied. This requirement shall not apply if a bait is used to attract the pest or pests or if the application is made indoors.

h. Amount of pesticide used, including:

(1) Pounds [kilograms] or gallons [liters] per acre [.40 hectare].

(2) Percentage or pounds [kilograms] of active ingredient.

(3) Pounds [kilograms] or gallons [liters] of tank mix applied per acre [.40 hectare].

i. Specific crops, commodities, and total acreage [hectarage] to which the pesticide was applied.

j. Description of equipment used in application.

k. Certification number of applicator, if any, and signature.

3. **Private applicators.** Private applicators shall keep a record of all restricted use pesticide applications. The records must include for each application:

a. Legal description of the land, grain bin identification (for fumigant or grain protectant applications), or other description of where the pesticide was applied.

b. Time the pesticide was applied (month, day, year, hours of the day).

c. Specific trade name of the pesticide applied and environmental protection agency registration number of the restricted use pesticide that was applied.

d. Amount of pesticide used, including:

(1) Pounds [kilograms] or gallons [liters] per acre [.40 hectare].

(2) Total amount applied.

e. Specific crops, commodities, and total acreage [hectarage] or other common identifying unit of measure, to which the pesticide was applied.

f. Certification number of applicator, if any, and signature.

Records made pursuant to this section shall be completed and made available for inspection on the day the pesticide is applied.

History: Amended effective October 1, 1990; May 1, 1994; March 1, 1996.
General Authority: NDCC 4-35-06
Law Implemented: NDCC 4-35-06, 4-35-16

60-03-01-09. Reports of pesticide accidents. Any person who causes a pesticide accident that results in unreasonable adverse effects on the environment shall report to the commissioner within twenty-four hours by letter or telephone ~~(224-2232)~~ (328-2232) the following information:

1. The name of the pesticide.

2. The amount of pesticide or tank mix, or both.

3. The location of the pesticide accident.

4. The time of accident (month, day, year, hour of the day).

5. The direction and estimated velocity of the wind and estimated temperature at the time of the accident, if outdoors.

6. Actions taken to remedy the adverse effects on humans, animals, and the environment.

History: Effective February 1, 1982; amended effective March 1, 1996.
General Authority: NDCC 4-35-21
Law Implemented: NDCC 4-35-21

TITLE 69

Public Service Commission

MAY 1996

ARTICLE 69-03

MOTOR CARRIER AUTHORITY AND OPERATIONS

[Repealed effective May 1, 1996]

CHAPTER 69-04-01

MOTOR CARRIER TARIFFS

[Repealed effective May 1, 1996]

CHAPTER 69-04-02

LOSS AND DAMAGE CLAIMS - COMMON CARRIERS

[Repealed effective May 1, 1996]

CHAPTER 69-04-03

69-04-03-01. Intrastate regulatory standards. Intrastate rail rates will be regulated in accordance with federal standards in effect as of September 1, ~~1993~~ 1995, prescribed in the Interstate Commerce Act [Title 49, United States Code], corresponding Interstate Commerce Commission rules [Title 49, Code of Federal Regulations], the interstate commerce commission decision In the Matter of Ex Parte 388 A, State Intrastate Rail Rates Authority, Public Law 96-448, Recertification Process, 5 I.C.C. 2d 680 (1989). ~~Copies of the laws and rules are available in the public service commission or the supreme court law library.~~

History: Effective September 1, 1982; amended effective February 1, 1991; January 1, 1994; May 1, 1996.
General Authority: NDCC 49-10.1-03
Law Implemented: NDCC 49-10.1-01

69-09-01-18.1. Discontinuance of gas service.

1. A utility may disconnect service if the customer is delinquent in payment for services rendered. However, no utility shall discontinue service to a customer for failure to pay for such service until the utility shall first have given the customer notice of its intention to discontinue such service on account of delinquency. The notice shall:

   a. Be sent by first-class mail addressed to the customer at the place where service is rendered, except that in the case of residential customers sixty-five years of age or older, or for handicapped customers, personal notice by delivery is required. A copy of each notice must also be mailed to the nearest social service office and to any other appropriate financial assistance agency, providing that prior approval has been given by the customer pursuant to subsection 2.

   b. Show the amount of the delinquency.

   c. Include the telephone number of the public service commission.

   d. Advise the customer of the customer's rights and remedies, including but not limited to the right of the customer to stay termination for up to thirty days if the customer advises the utility within the ten-day notice period that dangerous health conditions exist or that the customer is sixty-five years of age or older or that the customer is handicapped. In addition, the notice shall advise the customer of the customer's right to work out a satisfactory deferred installment agreement for delinquent accounts and of the opportunity to enter into equal monthly payment plans for future service.

   ~~d.~~ e. Inform the customer that service will be discontinued if the delinquent account is not paid within ten calendar days from the date of mailing or personal delivery of the notice, or if a satisfactory installment agreement is not made with the utility for payment of the delinquent bill.

   If the customer elects to enter into a deferred installment agreement for delinquent accounts, service may not be terminated; however, the utility may discontinue service without further notice if the customer fails to pay the delinquent account on or before the date specified in the notice, or in accordance with the deferred installment agreement. The customer shall have the privilege of paying

the delinquent account at any time prior to the actual disconnection of service, and the person directed by the utility to make the disconnection shall be deemed authorized and shall accept payment of the delinquent account if tendered to the person by the customer before actual disconnection of service is made.

2. It shall be the responsibility of all residential customers sixty-five years of age or older, handicapped, or having an emergency medical problem in the household, including life sustaining appliances, such as kidney dialysis, to notify the utility of such status. To assist in such notification, all utilities shall annually include a preaddressed postage-paid postcard in the monthly billing mailed to all residential customers during the billing period ending October first. Such notice shall also be provided to all new customers in that service area when they are first provided service by the utility.

   The postcard shall include the following questions:

	YES	NO
1. Is any member of your household 65 years of age or older, or handicapped?	___	___
2. Do you have any emergency medical problem in your household?	___	___
3. Do you desire that the area social service office or other appropriate financial assistance agency be notified in the event of a proposed disconnect?	___	___
4. Do you desire that some other third party be contacted in the event of a disconnect? If so, name and address of person _____ _____	___	___

5. If you are having difficulty paying your utility bill, please contact our local service representative or business office so that we can work with you on your problem.
   Utility Telephone Number _____
   Office Address _____

   Date _____ Name _____
   Address _____
   _____
   Signature

3. Service shall not be disconnected under this section on weekends, Fridays, state holidays, the day before a state

holiday, or after twelve noon on any day. Whenever service is disconnected under this section during the period October fifteenth to April fifteenth, the utility shall immediately notify the commission of the specific disconnection by telephone. A report describing the total number of actual disconnects, type of customer, and amount of delinquency for each disconnected customer shall be filed monthly with the commission within ten days after the last day of each month.

4. Whenever service has been disconnected for nonpayment of a bill, before reconnection is made the customer shall pay the reconnection fee established in the utility's rate schedules; make a deposit pursuant to section 69-09-02-04 if all or a part of the previous deposit was used in settlement of the delinquent bill; and make a satisfactory settlement for the delinquent bill and for service rendered between the last meter reading date and the date service was disconnected.

5. In the event the customer disputes the amount of a bill for service, the customer may, to prevent disconnection for nonpayment, pay the disputed bill under protest to the utility. Alternatively, the customer may request a formal hearing pursuant to section 69-02-02-02 in which case the utility shall not disconnect service for nonpayment of the disputed bill until a final decision has been issued by the commission. The utility shall immediately give the commission notice of the dispute and the commission may investigate the dispute. The utility shall refund to the customer any part of such payment made under protest found by the commission to be excessive.

6. A utility may not disconnect service to a customer for failure of the customer: to pay for merchandise purchased from the utility; to pay for a different class of service furnished by the utility; to pay for service rendered to a previous occupant of the premises; or to pay the bill of another customer as guarantor thereof.

7. A utility may discontinue service to a customer for failure to comply with regulations of the utility on file with the commission pertaining to installation and operation of utilization equipment, or for use of equipment which interferes with, or adversely affects, the service to other customers, provided the customer has first been notified and afforded reasonable opportunity to change or disconnect such equipment.

8. A utility may discontinue service to a customer upon ten days written notice if it is determined that the meter or other equipment installed by the utility has been tampered with, or if there has been a diversion of service, or if the customer is utilizing gas before the energy has passed through a meter

installed by the utility, or if a condition dangerous to life and property exists on the customer's premises.

9. Where a customer who has tenants is including the cost of utility services in the rent charged and the utility bill becomes delinquent, the utility before disconnecting service must also notify the tenants in writing at least ten days prior to the proposed termination date. The utility must allow each tenant to apply to become the customer of the utility in the tenant's own name, to have the service to the rental facility continued or resumed, and to pay the pro rata share of future bills. Such tenant-customer shall be subject to all the provisions of this chapter.

History: Effective October 1, 1980; amended effective May 1, 1996.
General Authority: NDCC 49-02-11
Law Implemented: NDCC 49-02-11

69-09-02-05.1. Discontinuance of electric service.

1. A utility may disconnect service if the customer is delinquent in payment for services rendered. However, no utility shall discontinue service to a customer for failure to pay for such service until the utility shall first have given the customer notice of its intention to discontinue such service on account of delinquency. The notice shall:

   a. Be sent by first-class mail addressed to the customer at the place where service is rendered, except that in the case of residential customers sixty-five years of age or older, or for handicapped customers, personal notice by delivery is required. A copy of each notice must also be mailed to the nearest social service office and to any other appropriate financial assistance agency, providing that prior approval has been given by the customer pursuant to subsection 2.

   b. Show the amount of the delinquency.

   c. Include the telephone number of the public service commission.

   d. Advise the customer of the customer's rights and remedies, including, but not limited to, the right of the customer to stay termination for up to thirty days if the customer advises the utility within the ten-day notice period that dangerous health conditions exist or that the customer is sixty-five years of age or older or that the customer is handicapped. In addition, the notice shall advise the customer of the customer's right to work out a satisfactory deferred installment agreement for delinquent accounts and of the opportunity to enter into equal monthly payment plans for future service.

   ~~d.~~ e. Inform the customer that service will be discontinued if the delinquent account is not paid within ten calendar days from the date of mailing or personal delivery of the notice, or if a satisfactory installment agreement is not made with the utility for payment of the delinquent bill.

   If the customer elects to enter into a deferred installment agreement for delinquent accounts, service may not be terminated; however, the utility may discontinue service without further notice if the customer fails to pay the delinquent account on or before the date specified in the notice, or in accordance with the deferred installment agreement. The customer shall have the privilege of paying

the delinquent account at any time prior to the actual disconnection of service, and the person directed by the utility to make the disconnection shall be deemed authorized and shall accept payment of the delinquent account if tendered to the person by the customer before actual disconnection of service is made.

2. It shall be the responsibility of all residential customers sixty-five years of age or older, handicapped, or having an emergency medical problem in the household, including life-sustaining appliances, such as kidney dialysis, to notify the utility of such status. To assist in such notification, all utilities shall annually include a preaddressed postage-paid postcard in the monthly billing mailed to all residential customers during the billing period ending October first. Such notice shall also be provided to all new customers in that service area when they are first provided service by the utility.

   The postcard shall include the following questions:

	YES	NO
1. Is any member of your household 65 years of age or older, or handicapped?	___	___
2. Do you have any emergency medical problem in your household?	___	___
3. Do you desire that the area social service office or other appropriate financial assistance agency be notified in the event of a proposed disconnect?	___	___
4. Do you desire that some other third party be contacted in the event of a disconnect? If so, name and address of person _____ _____	___	___

5. If you are having difficulty paying your utility bill, please contact our local service representative or business office so that we can work with you on your problem.

   Utility Telephone Number _____
   Office Address _____

   Date _____ Name _____
   Address _____
   _____
   Signature

3. Service shall not be disconnected under this section on weekends, Fridays, state holidays, the day before a state holiday, or after twelve noon on any day. Whenever service is disconnected under this section during the period October fifteenth to April fifteenth, the utility shall immediately notify the commission of the specific disconnection by telephone. A report describing the total number of actual disconnects, type of customer, and amount of delinquency for each disconnected customer shall be filed monthly with the commission within ten days after the last day of each month.

4. Whenever service has been disconnected for nonpayment of a bill, before reconnection is made the customer shall pay the reconnection fee established in the utility's rate schedules; make a deposit pursuant to section 69-09-02-04 if all or a part of the previous deposit was used in settlement of the delinquent bill; and make a satisfactory settlement for the delinquent bill and for service rendered between the last meter reading date and the date service was disconnected.

5. In the event the customer disputes the amount of a bill for service, the customer may, to prevent disconnection for nonpayment, pay the disputed bill under protest to the utility. Alternatively, the customer may request a formal hearing pursuant to section 69-02-02-02 in which case the utility shall not disconnect service for nonpayment of the disputed bill until a final decision has been issued by the commission. The utility shall immediately give the commission notice of the dispute, and the commission may investigate the dispute. The utility shall refund to the customer any part of such payment made under protest found by the commission to be excessive.

6. A utility may not disconnect service to a customer for failure of the customer: to pay for merchandise purchased from the utility; to pay for a different class of service furnished by the utility; to pay for service rendered to a previous occupant of the premises; or to pay the bill of another customer as guarantor thereof.

7. A utility may discontinue service to a customer for failure to comply with regulations of the utility on file with the commission pertaining to installation and operation of utilization equipment, or for use of equipment which interferes with, or adversely affects, the service to other customers, provided the customer has first been notified and afforded reasonable opportunity to change or disconnect such equipment.

8. A utility may discontinue service to a customer upon ten days' written notice if it is determined that the meter or other equipment installed by the utility has been tampered with, or if there has been a diversion of service, or if the customer

is utilizing electricity before the energy has passed through a meter installed by the utility, or if a condition dangerous to life and property exists on the customer's premises.

9. Where a customer who has tenants is including the cost of utility services in the rent charged and the utility bill becomes delinquent, the utility before disconnecting service must also notify the tenants in writing at least ten days prior to the proposed termination date. The utility must allow each tenant to apply to become the customer of the utility in the tenant's own name, to have the service to the rental facility continued or resumed, and to pay the pro rata share of future bills. Such tenant-customer shall be subject to all the provisions of this chapter.

History: Effective October 1, 1980; amended effective May 1, 1996.
General Authority: NDCC 49-02-11
Law Implemented: NDCC 49-02-11

69-09-05-02. Discontinuance of telecommunications services. A utility may not discontinue telecommunications services, except as provided in this section.

1. A utility may discontinue the essential services it provides:

   a. If the customer is delinquent in payment for essential services, then essential services may be discontinued even though discontinuing the services results in the discontinuance of all telecommunication services.

   b. If the customer is delinquent in payment for long-distance services rendered by a local exchange company or another company and billed by the local exchange company, but is not delinquent in payment for essential services rendered by the local exchange company, the local exchange company may discontinue the customer's local exchange services only at central offices lacking the technical ability to discontinue long-distance services while continuing to provide local exchange services.

2. A utility may discontinue nonessential services:

   a. If the customer is delinquent in payment for nonessential services.

   b. If the customer is delinquent in payment for long-distance telecommunications services rendered by another company and billed by the local exchange company, then the local exchange company may deny the customer all forms of access to the network of the telecommunications company to which the customer is delinquent in payment. However, if, due to technical limitations, a local exchange company must also deny the customer all forms of access to the long-distance networks of all telecommunications companies, including its own, in order to deny the customer access to the network of the company to which the customer is delinquent, the local exchange company may do so.

3. A utility may discontinue service to a customer for failure to comply with regulations of the utility on file with the commission pertaining to installation and use of equipment, or for use of equipment which interferes with or adversely affects the service to other customers, provided the customer has first been notified and afforded reasonable opportunity to change or disconnect such equipment.

4. A utility may not discontinue service to a customer for failure of the customer to pay for merchandise purchased from the utility, to pay for a different class of service furnished by the utility, to pay for service rendered to a previous occupant of the premises, or to pay the bill of another customer as guarantor thereof.

5. A utility may not discontinue service to a customer for failure to pay for service until the utility first gives the customer notice of its intention to discontinue such service on account of delinquency. The notice must:

   a. Be sent by first-class mail addressed to the billing name and address of the affected account.

   b. Show the amount of the delinquency.

   c. Include the telephone number of the public service commission.

   d. Advise the customer of the customer's rights and remedies, including the customer's right to work out a satisfactory deferred installment agreement for delinquent accounts.

   ~~d.~~ e. Inform the customer that service will be discontinued if the delinquent account is not paid within ten calendar days from the date of mailing or personal delivery of the notice, or if a satisfactory installment agreement is not made with the utility for payment of the delinquent bill. The utility may discontinue service without further notice if the customer fails to pay the delinquent account by the due date.

6. a. A deferred installment agreement for essential services may not be combined with a deferred installment agreement for any other services.

   b. A utility may not discontinue essential services if the utility and the customer make a mutually agreed upon deferred installment agreement for essential services. A utility may discontinue essential services without further notice if the customer fails to pay the delinquent account in accordance with the deferred installment agreement.

   c. A utility may not discontinue nonessential services if the utility and the customer make a mutually agreed upon deferred installment agreement for nonessential services. A utility may discontinue nonessential services without further notice if the customer fails to pay the delinquent account in accordance with the deferred installment agreement.

7. The customer may pay the delinquent account at any time prior to the actual discontinuance of service.

8. Whenever service has been discontinued for nonpayment of a bill, service must be resumed if the customer:

   a. Pays the fee for resuming service established in the utility's rate schedules;

   b. Makes a deposit under section 69-09-05-03 (if required by the company); and

   c. Makes a satisfactory settlement for the delinquent bill and for the service rendered to the date the service was discontinued.

   Interexchange carriers are not required to resume long-distance service if local service is not connected.

9. If the customer disputes the amount of a bill for service, the customer may, to prevent discontinuance for nonpayment, pay the disputed bill under protest to the utility. Alternatively, the customer may request a formal hearing pursuant to section 69-02-02-02 in which case the utility may not discontinue service for nonpayment of the disputed bill until a final decision has been issued by the commission. The utility shall immediately give the commission notice of the dispute and the commission may investigate the dispute. The utility shall refund to the customer any part of such payment made under protest found by the commission to be excessive.

10. The commission may order the discontinuance of services where a reseller, or operator services provider, ~~or customer-owned pay telephone provider~~ violates commission rules. The commission will provide ten days' notice of a deficiency or violation and provide an opportunity for the noncomplying reseller, or operator services provider, ~~or customer-owned pay telephone operator~~ to respond or correct the deficiency. A reseller, or operator services provider, ~~or customer-owned pay telephone provider~~ disputing the alleged violation or discontinuance, may request a formal hearing under section 69-02-02-02, in which case the discontinuance will be stayed until final decision by the commission.

History: Effective April 1, 1985; amended effective January 1, 1993; May 1, 1996.
General Authority: NDCC 49-02-11
Law Implemented: NDCC 49-02-11, 49-21-01.4

69-09-05-05. Rules for the provision of operator services.

1. Definitions.

a. "End user" means the person to whom operator service is provided.

b. "Operator service" means service provided to assist in the completion or billing of telephone calls through the use of a live operator or automated equipment. "Operator service" does not include completion of calls through an 800 number or an access code when billed to an account previously established with the carrier by the end user, or the automated operator services provided by pay telephone sets with built-in automated operator messages.

c. "Operator service provider" means the person providing operator service.

2. Operator service providers shall:

a. Obtain a certificate of registration from the commission authorizing the provision of operator services in the state of North Dakota.

~~b.--File--tariffs--containing--rates,--charges,--and-rules-for operator--services,--as--well--as---for---any---associated intrastate---long-distance---resale---services,--with--the commission.--This-filing-is-for-informational-purposes.~~

~~c.--File---service--quality--standards--relating--to--operator response,-including-emergency-calls,-and--call--processing time-with-the-commission-for-informational-purposes.~~

~~d.~~ b. Provide written material for use in disclosing to the end user the name and toll free telephone number of the operator service provider. This material must be provided to all coin telephone operators, motels, hospitals, and any other locations where end users may use telephone service not billable to their home or business phones without operator service.

~~e.~~ c. Require operators to clearly identify the operator service provider to all end users and when requested, provide rate information.

~~f.~~ d. Provide emergency call service that is equal to that provided by the local exchange telephone company and, if unable to meet this requirement, provide emergency call service by immediate transfer of such calls to the local exchange company.

~~g.~~ e. For billing purposes, itemize, identify, and rate calls from the point of origination to the point of termination. No call may be transferred to another carrier by an operator service provider which cannot or will not

complete the call, unless the call can be billed in accordance with this subsection.

h. f. Not charge for incompleted calls.

~~i.--Bill-for-their-services-only-and-at-the-rates-contained-in their-filed-tariffs.~~

j. g. Disclose their names on bills which include charges for services they provided.

History: Effective March 1, 1989; amended effective August 1, 1991; May 1, 1996.
General Authority: NDCC 28-32-02, 49-02-11
Law Implemented: NDCC 49-02-11, 49-21

TITLE 70

Real Estate Commission

APRIL 1996

CHAPTER 70-01-02

70-01-02-01. Place of hearing. All hearings shall be held ~~in the county where the applicant or salesperson resides or has the place of business, unless the applicant, broker, or salesperson, by written waiver, consents to a change of place~~ at a location designated by the commission in its notice of hearing. ~~In such case the commission may, in its discretion, designate another place of hearing.~~

History: Amended effective January 1, 1992; April 1, 1996.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-11.1(3)

70-02-03-17. Designated broker - Appointed agent.

1. Responsibilities of designated broker. The designated broker must have a written company policy that identifies and describes the types of real estate agency relationships in which the agency may engage. In addition, any agency that offers representation to both buyers and sellers must also address in the policy manual the agency's procedures intended to prevent any mishandling of information through both formal and informal sharing of information within the agency, the arrangement of agency office space, and the personal relationships of appointed agents who are representing clients with adverse interests.

2. Appointed agent procedures and disclosure.

   a. A designated broker appointing a licensee to act as an agent of a client shall take ordinary and necessary care to protect confidential information disclosed by the client to the appointed agent.

   b. An appointed agent may reveal to the agency's designated broker confidential information of a client for seeking advice or assistance for the benefit of the client about a possible transaction. The designated broker shall treat confidential information as such and may not disclose such information unless otherwise requested or permitted by the client who originally disclosed the confidential information.

3. Appointed agent - Written disclosure.

   a. An appointed agent shall disclose in writing such appointment to the client before entering into a brokerage agreement and shall include, at a minimum, the following provisions:

      (1) The name of the appointed agent;

      (2) A statement that the appointed agent will be the client's agent and will owe the client fiduciary duties, which, among other things, include the obligation not to reveal confidential information obtained from the client to other licensees, except to the designated broker for seeking advice or assistance for the benefit of the client;

(3) A statement that the agency may be representing both the seller and the buyer in connection with the sale or purchase of real estate;

(4) A statement that other licensees may be appointed during the term of the brokerage agreement should the appointed agent not be able to fulfill the terms of the brokerage agreement or as by agreement between the designated broker and client. An appointment of another agent as a new or additional agent does not relieve the first appointed agent of any of the fiduciary duties owed to the client. At the time of the appointment of the new or additional agents, the designated broker must comply with the provisions of this section; and

(5) A section for the client to consent or not consent, in writing, to the appointment.

4. Appointed agent's duty to the designated broker. In any appointed agent transaction, the appointed agent shall keep the designated broker fully informed of all activities conducted by the appointed agent during the transaction and shall notify the designated broker of any other activities that might affect the responsibility of the designated broker.

History: Effective April 1, 1996.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 43-23-12.3

TITLE 71

Retirement Board

JUNE 1996

CHAPTER 71-02-01

71-02-01-01. Definitions. As used in North Dakota Century Code chapter 54-52 and this article:

1. "Accumulated contributions" means the total of all of the following:

   a. The employee account fund balance accumulated under the prior plan as of June 30, 1977.

   b. The vested portion of the employee's "vesting fund" accumulated under the prior plan as of June 30, 1977.

   c. The member's mandatory contributions made after July 1, 1977.

   d. The interest on the sums determined under subdivisions a, b, and c, compounded annually at the rate of five percent from July 1, 1977, to June 30, 1981, six percent from July 1, 1981, through June 30, 1986, and one-half of one percent less than the actuarial interest assumption from July 1, 1986, to the member's termination of employment or retirement.

   e. The sum of any employee purchase or repurchase payments.

2. "Actuarial equivalent" means a benefit calculated to be of equal value to the benefit otherwise payable when computed on the basis of assumptions and methods adopted for this purpose by the board.

3. "Alternative retirement system" means the teachers' fund for retirement, the highway patrolmen's retirement system, and the teachers' insurance and annuity association of America.

4. "Beneficiary" means any person in receipt of a benefit provided by this plan or any person designated by a participating member to receive benefits.

5. "Bonus" means cash compensation for services performed in addition to base salary excluding commission and shift differentials. Bonus does not include lump sum payments of sick leave provided under North Dakota Century Code section 54-06-14 or lump sum payments of annual leave or vacation pay.

6. "Claim" means the right to receive a monthly retirement allowance, the receiving of a retirement allowance, or the receiving of a disability benefit.

7. "Continuously employed" means any period of employment uninterrupted by voluntary or involuntary termination or discharge. A member who has taken a leave of absence approved by the member's employer, not to exceed a year unless approved by the executive director, and returns to employment shall be regarded as continuously employed for the period.

8. "Contribution" means the payment into the fund of nine and twelve-hundredths percent of the salary of a member.

9. "County judge" means a judge who was elected pursuant to North Dakota Century Code section 27-07.1-01 or an individual holding the position of county judge, county justice, or judge of county court prior to the general election in 1982, who meet all the eligibility requirements established under chapter 54-52.

10. "Interruption of employment" is when an individual is inducted (enlists or is ordered or called to active duty into the armed forces of the United States) and leaves an employment position with a state agency or political subdivision, other than a temporary position. The individual must have left employment to enter active duty and must make application for reemployment within ninety days of discharge under honorable conditions.

11. "Leave of absence" means the period of time up to one year for which an individual may be absent from covered employment without being terminated. At the executive director's discretion, the leave of absence may be extended not to exceed two years.

12. "Medical consultant" means a person or committee appointed by the board of the North Dakota public employees retirement system to evaluate medical information submitted in relation

to disability applications, recertifications, and rehabilitation programs or other such duties as assigned by the board.

13. "Office" means the administrative office of the public employees retirement system.

14. "Participating employer" means an employer who contributes to the North Dakota public employees retirement system.

15. "Pay status" means a member is receiving a retirement allowance from the fund.

16. "Permanent and total disability" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months.

17. "Plan administrator" means the executive director of the North Dakota public employees retirement system or such other person or committee as may be appointed by the board of the North Dakota public employees retirement system from time to time.

18. "Plan year" means the twelve consecutive months commencing July first of the calendar year and ending June thirtieth of the subsequent calendar year.

19. "Prior plan" means the state employees' retirement system which existed from July 1, 1966, to June 30, 1977.

20. "Regularly funded" means a legislatively authorized full-time equivalent (FTE) position for state agencies. For all governmental units other than state agencies, regularly funded means a similar designation by the unit's governing board which is created through the regular budgeting process and receives traditional employee benefits such as sick leave and annual leave.

21. "Retiree" means an individual receiving a monthly allowance pursuant to chapter 54-52.

~~21.~~ 22. "Service credit" means increments of time to be used in the calculation of retirement benefits. Service credit may be earned as stated in section 71-02-03-01 or may be purchased or repurchased according to section 71-02-03-02.1.

~~22.~~ 23. "Substantial gainful activity" is to be based upon the totality of the circumstances including: consideration of an individual's training, education, experience, their potential for earning at least seventy percent of their predisability earnings; and other items deemed significant on a case-by-case

basis. Eligibility is based on an individual's employability and not actual employment status.

~~23.~~ 24. "Termination of employment" means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence does not constitute termination of employment.

History: Amended effective September 1, 1982; November 1, 1990; September 1, 1991; January 1, 1992; September 1, 1992; June 1, 1993; July 1, 1994; June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52

CHAPTER 71-02-02

71-02-02-01. Membership - General rule. Each eligible employee shall become a member of the public employees retirement system upon filing a membership form with the office, and the beginning of contributions to the fund. In addition, the following requirements apply:

1. A temporary employee must complete a participation agreement before becoming a member. Application must be completed within: Six months of the date of hire as a temporary employee, or within six months of a change in status from a permanent position to temporary.

2. Contributions for temporary employees must be submitted no later than the sixth working day of the month for the previous month's salary.

3. Delinquent payments of over thirty days, for reasons other than leave of absence or seasonal employment, will result in termination of eligibility to participate as a temporary member for the remainder of the plan year.

4. Upon taking a refund, future participation as a temporary member is waived.

5. A member may not participate as both a permanent and a temporary member. Permanent employment has precedence.

6. An elected official must enroll or waive participation in writing within six months of taking office.

History: Amended effective September 1, 1982; November 1, 1990; September 1, 1992; June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-01(3), 54-52-02.9, 54-52-05

71-02-03-01. Service credit - General rule. A member receives credit for each month a contribution is made ~~except--if--the--enrollment date--is--after--the--fifteenth-of-the-month.--If-the-enrollment-date-is after--the--fifteenth,--then---the---member's---enrollment---date---will automatically--be--the-next-month~~. Service credit shall be granted upon proper verification without member contribution after an employee has participated in eligible employment not less than two years for:

1. Prior service employment.

2. Probationary employment prior to July 1, 1979, that was previously excluded from eligible employment.

3. Eligible employment between the ages of eighteen and twenty-one that was previously excluded by the age limitation of twenty-one for participation in the retirement program.

4. Summer months for eligible school employees for the period July 1, 1979, to July 1, 1982.

5. Former members of the teachers' fund for retirement, job service North Dakota, or highway patrolmen's retirement systems will be granted credit for previous service in these funds if they received a lump sum refund prior to September 1, 1976.

History: Amended effective September 1, 1982; November 1, 1990; June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-01(11)(12)(16), 54-52-17

71-02-03-01.2. Service credit given for leave taken. A member may take leave pursuant to policies, rules, and statutes applicable to the member's employing unit. However, service credit may only be given for leave that is part of a participating member's continuous service. Service credit may not be given for isolated leave that is not part of continuous service.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-01(11)(12)(16), 54-52-17

71-02-03-02.1. Purchase of additional service credit and repurchase of past service. In order to purchase additional credit or repurchase past service, a ~~participating~~ member, or a participating member of an alternative retirement system, must notify the office, in writing, of the service for which they wish to receive credit. In addition to the written request, the following information must be submitted if applicable:

1. Verification by the former employer of previous North Dakota or out-of-state public service, or service with the federal government.

2. Documentation of military service by submitting a DD214 or NGB22.

3. Certification of approval by the member's employer of any leave of absence and length of that leave.

4. Verification of current average monthly salary and current service credit by the employer of members participating in an alternative retirement system.

5. Statement from employee or former employer that service credit being applied for does not qualify for retirement benefits under another retirement system.

History: Effective November 1, 1990; amended effective July 1, 1994; June 1, 1996.
General Authority: NDCC 54-52-02.6, 54-52-04, 54-52-17, 54-52-17.2, 54-52-17.4
Law Implemented: NDCC 54-52-02.6, 54-52-17, 54-52-17.2, 54-52-17.4

71-02-03-02.2. Payment. The total dollar amount for the purchase or repurchase may be paid in a lump sum or on a monthly, quarterly, semiannual, or annual basis. Payments are subject to contribution limitations established under 26 U.S.C. 415. Payments must begin within

ninety days of the date the written cost confirmation is prepared ~~for the participating member or participating member of an alternative retirement system~~. If the installment method is used, the following conditions apply:

1. Simple interest at the actuarial rate of return ~~will~~ must accrue monthly on the unpaid balance. Interest is calculated from the fifteenth of each month.

2. ~~A minimum payment of fifty dollars per month is required.~~

3. The installment schedule may ~~not exceed~~ extend for a maximum term of ten years or the number of years until the member meets normal retirement age, whichever is greater.

~~4. There is no penalty for early payoff.~~

~~5.~~ 3. Installment payments ~~can~~ may be made by a payroll deduction where available. However, it is the responsibility of the member to initiate and terminate the payroll deduction. ~~Payments are due by the fifteenth of the month to be credited for the month.~~

~~6.~~ 4. Payments may only be received ~~from participating members or participating members of an alternative retirement system. Payments from separating or retiring members may only be received up~~ until the fifteenth of the month in which the ~~member's last retirement contribution is received~~ member retires or takes a lump sum refund.

5. Payments are due by the fifteenth of the month to be credited for the month.

History: Effective November 1, 1990; amended effective July 1, 1994; June 1, 1996.
General Authority: NDCC 54-52-02.6, 54-52-04, 54-52-17, 54-52-17.2, 54-52-17.4
Law Implemented: NDCC 54-52-02.6, 54-52-17, 54-52-17.2, 54-52-17.4

71-02-03-02.3. Delinquent payment. If no payment is received within thirty days of the due date, the public employees retirement system shall send a letter to the ~~participating~~ member ~~or member of an alternative retirement system~~ advising them of the delinquency. If no payment is received within sixty days after the due date, the account must be closed. Payments received on any closed ~~account will~~ accounts must be returned to the member.

History: Effective November 1, 1990; amended effective July 1, 1994; June 1, 1996.
General Authority: NDCC 54-52-02.6, 54-52-04, 54-52-17, 54-52-17.2, 54-52-17.4
Law Implemented: NDCC 54-52-02.6, 54-52-17, 54-52-17.2, 54-52-17.4

71-02-03-02.4. Crediting purchased or repurchased service. Service purchased or repurchased will be credited in the following manner:

1. The ~~employee's~~ member's record ~~will~~ must be updated with the additional service credit once the account is paid in full.

2. If the member ~~or member of an alternative retirement system~~ terminates takes a refund, retires, or the member's account is closed due to delinquency, service credit ~~will~~ must be granted ~~in proportion to the actual payments~~ by taking the months of service credit being purchased times the percentage paid. The percentage is determined by taking the total payments made towards the purchase divided by the total amount to be paid over the term of the purchase. Fractions of service credit must be rounded to the nearest whole month.

3. For members converting service under the public employees retirement system to service under the judge's retirement system, each month of county judge service under the public employees retirement system will be converted to one month of judicial service credit.

History: Effective November 1, 1990; amended effective July 1, 1994; June 1, 1996.
General Authority: NDCC 54-52-02.6, 54-52-04, 54-52-17, 54-52-17.2, 54-52-17.4
Law Implemented: NDCC 54-52-02.6, 54-52-17, 54-52-17.2, 54-52-17.4

71-02-03-02.5. Costs. The cost ~~will~~ must be calculated by applying actuarial factors to the amount of retirement and ~~prefunded~~ retiree health ~~benefits~~ insurance credit being purchased by the ~~participating~~ member ~~or member of an alternative retirement system~~. The member's current age, average salary as calculated under subsection 2 of North Dakota Century Code section 54-52-17, and current credited service on record with the North Dakota public employees retirement system in the month in which the member's written request is received ~~will~~ must be used in the cost calculation. The amount of retirement and ~~prefunded~~ retiree health ~~benefits~~ insurance credit being purchased ~~will~~ must be calculated using the benefit formulas in place at the time the written request is received from the member. When calculating the cost, enhancements to the benefit formula ~~will~~ must be considered to be in place at the time the law is signed by the governor.

The retirement board ~~will~~ must adopt actuarial assumptions necessary to determine the actuarial factors for the cost calculation. The assumptions ~~will~~ must be reviewed concurrently with the assumptions for the retirement program.

Upon receipt of the written request from the member, and all required documentation, a written cost confirmation ~~will~~ must be prepared and mailed to the member. The cost stated in the confirmation

letter ~~will be~~ is valid for a period of ninety days from the date of the letter.

History: Effective July 1, 1994; amended effective June 1, 1996.
General Authority: NDCC 54-52-02.6, 54-52-04, 54-52-17, 54-52-17.2, 54-52-17.4
Law Implemented: NDCC 54-52-02.6, 54-52-17, 54-52-17.2, 54-52-17.4

71-02-03-05. Coordination of multiple plan membership. Upon providing proper documentation of retirement plan participation, a member who meets the following criteria may use service credit in the teachers' insurance retirement fund for the purpose of meeting the rule of eighty-eight or for vesting purposes under North Dakota Century Code chapter 54-52. The member:

1. Must have participated in both the teachers' fund for retirement and the teachers' insurance and annuity association of America-college retirement equities fund.

2. Must have elected to transfer the member's teachers' insurance retirement fund account balance to teachers' insurance and annuity association of America-college retirement equities fund in connection with the administrative coordination of the various state retirement plans as provided under chapter 133 of the 1973 North Dakota Session Laws.

3. Did not have a cash out since the time of the transfer of funds.

4. Did not relinquish such service credit in writing.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-01(11)(12)(16), 54-52-17

71-02-03-06. Conversion of sick leave. To convert unused sick leave to service credit, the member must notify the office, in writing, of the amount of unused sick leave to be converted and the member's employer must confirm the member's unused balance of accumulated sick leave as of the date the member terminates employment. One month of service credit must be awarded for each one hundred seventy-three and three-tenths hours of unused accumulated sick leave. The employer and employee contributions rates used to calculate the cost must be the rate of the retirement program of the member at termination.

Payments may be accepted from the member as early as six months prior to termination if the following requirements are met:

1. A notice of termination or application for monthly benefits form is on file with the public employees retirement system.

2. A written certification by the member's employer, as to the member's unused balance of accumulated sick leave as of the date the member wishes to begin payment, is on file with the public employees retirement system.

3. The sick leave conversion payment must be within the contribution limits of 26 U.S.C. 415.

4. At termination, the sick leave conversion payment must be recalculated using the member's unused balance of accumulated sick leave confirmed by the member's employer, and the member's final average salary as of that date.

   If there is a difference between the sick leave conversion payment amount and the amount the member has paid, any overpayment must be refunded to the member and any underpayment must be collected from the member within sixty days of termination.

The member's record must be updated with the additional service credit once payment is made in full and the member has terminated employment.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-17.8, 54-52-27

71-02-04-02.1. Application processing. The termination date for purposes of processing an application for retirement benefits must be the last date for which a member receives salary except for a member who is on an approved leave of absence. For members who are paid salary in any month following actual separation from employment where the salary is received after the normal processing date, the termination date for purposes of processing the application must be the same date as the date that the last paycheck was issued as salary.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-17

71-02-04-07. Amount of early retirement benefit.

1. ~~The~~ Except for members of the national guard security police and firefighters retirement system, the early retirement benefit shall be an amount actuarially reduced from the ~~normal~~ single life retirement benefit by one-half of one percent for each month (six percent per year) that the member is younger than age sixty-five on the date the member's early retirement benefit commences.

2. For members of the national guard security police and firefighters retirement system, the early retirement benefit must be an amount actuarially reduced from the single life retirement benefit by one-half of one percent for each month (six percent per year) that the member is younger than age fifty-five on the date the member's early retirement benefit commences.

History: Amended effective September 1, 1982; June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-17

71-02-04-09. Dual membership - Receipt of retirement benefits while contributing to the teachers' fund for retirement, the highway patrolmen's retirement system, or the teachers' insurance and annuity association of America-college retirement equities fund.

1. Dual members must select one of the following options:

   a. Begin receiving retirement benefits from one plan prior to ceasing employment covered by the alternate plan.

b. Begin receiving retirement benefits from one plan and begin work in a job covered by the alternate plan.

c. Continue as a dual member and begin receiving retirement benefits from both plans after ceasing employment.

2. For purposes of determining eligibility for benefits under subsection 2 of North Dakota Century Code section 54-52-17, an employee's years of service credit is the total of the years of service employment earned in the public employees retirement system and the years of service employment earned in:

a. The teachers' fund for retirement.

b. The highway patrolmen's retirement system.

c. The teachers' insurance and annuity association of America-college retirement equities fund.

3. A member's combined service credit must not exceed twelve months per calendar year. If a member's combined months of service is less than twelve months, the member will be credited with a fractional year of service, determined by dividing the combined total by twelve.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17, 54-52-17.2
Law Implemented: NDCC 54-52-17, 54-52-17.2

71-02-04-09.1. Dual membership limitations. The following limitations apply when a member elects an option under subsection 1 of section 71-02-04-09.

1. Eligible service credit may be used for vesting purposes and determining when the dual member may begin drawing normal retirement benefits. A member may begin drawing normal retirement benefits from one fund and use the same years, and any additional years, for reaching normal retirement from the alternate fund if the service credit is earned at different times.

2. If a dual member elects to receive retirement benefits as provided in subdivision a or b of subsection 1 of section 71-02-04-09, the final average salary, service credit, and member's age used to calculate the benefit that is applicable at the time retirement benefits begin may not be adjusted after the benefit effective date.

3. The final average salary used in calculating the retirement benefit must be certified in writing by the fund of last membership. The final average salary established at the time

retirement benefits begin must be fixed for pension calculation purposes. Benefits may not be recalculated using salaries earned after the benefit effective date.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17, 54-52-17.2
Law Implemented: NDCC 54-52-17, 54-52-17.2

71-02-04-10. Erroneous payment of benefits - Overpayments.

1. An "overpayment" means a payment of money by the public employees retirement system that results in a person receiving a higher payment than the person is entitled to under the provision of the retirement plan of membership.

2. A person who receives an overpayment is liable to refund those payments upon receiving an explanation and a written request for the amount to be refunded from the executive director. All overpayments must be collected using the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like gains. If the cost of recovering the amount of the overpayment is estimated to exceed the overpayment, the repayment is considered to be unrecoverable.

3. If the overpayment of benefits was not the result of any wrongdoing, negligence, misrepresentation, or omission by the recipient, the recipient may make repayment arrangements subject to the executive director's approval within sixty days of the written request for refund. If repayment arrangements are not in place within sixty days of the date of the written notice of overpayment, the executive director shall offset the amount of the overpayment from the amount of future retirement benefit payments so that the actuarial equivalent of the overpayment is spread over the individual's benefit payment period.

4. If the overpayment of benefits was the result, in whole or in part, of the wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of six percent on the outstanding balance, from the time the erroneous benefit was paid through the time it has been refunded in full, plus applicable interest.

5. If an individual dies prior to fully refunding an erroneous overpayment of benefits, the public employees retirement system must make application to the estate of the deceased to recover the remaining balance.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-17

71-02-04-11. Erroneous payment of benefits - Underpayments.

1. An "underpayment" means a payment of money by the public employees retirement system that results in a person receiving a lower payment than the person is entitled to under the provisions of the retirement plan of membership.

2. If an underpayment occurs, the amount of the lump sum payment must be paid within thirty days of the discovery of the error, with interest at the rate of six percent from the time underpayment occurred.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-17

71-02-04-12. Erroneous payment of benefits - Appeals.

1. A person not satisfied with repayment arrangements made under section 71-02-04-10 may appeal the executive director's decision in writing to the board. The written request must explain the basis of the appeal and must be received in the office within sixty days of the executive director's written decision.

2. The board may release a person from liability to refund an overpayment, in whole or in part, if it determines:

   a. The receipt of overpayment is not the fault of the recipient.

   b. It would be contrary to equity and good conscience to collect the refund.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52-17
Law Implemented: NDCC 54-52-17

71-02-04-13. Reduced benefit option. A participating member may enter into an agreement with the retirement board to receive an actuarially adjusted monthly retirement benefit to accommodate the less

than full payment for years of service credit necessary to meet the rule of eighty-eight, if the following criteria are met:

1. The participating member is at least fifty years old and has twenty or more years of credited service in the retirement system.

2. The amount of time to be purchased, or sick leave to be converted, does not exceed one hundred twenty months.

3. The service cannot be purchased, or the sick leave cannot be converted, prior to the participating member drawing a retirement benefit because it would be in violation of 26 U.S.C. 415.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-17.8

71-02-05-06. Determination of disability - Procedures.

1. **Application.**

   a. If the member is unable or unwilling to file an application, the member's legal representative may file the member's disability application.

   b. The application must explain the cause of the disability, the limitations caused by the disability, the treatment being followed, and the effect of the disability on the individual's ability to be engaged in any gainful occupation for which the person is, or could become, reasonably fitted by education, training, or experience.

   c. The application must be filed with the executive director and may not be filed earlier than one hundred twenty days before the expected termination date.

2. **Medical consultant.**

   a. The board may retain a medical consultant to evaluate and make recommendations on disability retirement applications.

   b. The medical consultant shall review all medical information provided by the applicant.

   c. The medical consultant is responsible to determine eligibility for disability benefits for applicants not approved for social security disability benefits and shall advise the executive director of the decision in writing. Applicants who become eligible for disability benefits under the Social Security Act and who meet the requirements of subdivision e of subsection 3 of North Dakota Century Code section 54-52-17 are eligible for benefits under subdivision e of subsection 4 of North Dakota Century Code section 54-52-17 without submitting further medical information to the medical advisor, but are subject to recertification requirements specified in this chapter.

   d. (1) ~~The~~ If the applicant has terminated employment, the executive director shall notify the applicant in writing of the decision. If the applicant is determined not to be eligible for disability benefits, the executive director shall advise the applicant of the appeal procedure. If the applicant is ~~deemed~~ determined eligible for disability

benefits, benefits must be paid pursuant to subsection 5.

(2) If the applicant has not terminated employment, the applicant must be provided with a preliminary notification of the decision in writing. The preliminary notification remains in effect for a period not to exceed two hundred seventy days. If an applicant does not terminate employment within two hundred seventy days of the date of termination provided on the disability application, the application must be considered to be vacated but the applicant may reapply as provided in subsection 1.

3. **Medical examination.**

a. The applicant for disability retirement shall provide the medical examination reports as requested by the medical consultant.

b. The member is liable for any costs incurred by the member in undergoing medical examinations and completing and submitting the necessary medical examination reports, medical reports, and hospital reports necessary for initial determination of eligibility for benefits.

If determined to be eligible for disability benefits, the member must be reimbursed up to four hundred dollars for the cost of medical examinations specifically requested by the medical adviser and the executive director.

4. **Appeal.**

a. The applicant may appeal an adverse determination to the board by providing a written notice of appeal within ~~sixty~~ thirty days of the date that the plan administrator mailed the decision.

b. The board shall consider all appeals at regularly scheduled board meetings. The applicant must be notified of the time and date of the meeting and may attend ~~or~~ and be represented by legal counsel. The executive director shall provide to the board for its consideration a case history brief that includes membership history, medical examination summary, and the plan administrator's conclusions and recommendations. The board shall make the determination for eligibility at the meeting unless additional evidence or information is needed. The discussion concerning disability applications must be confidential and closed to the general public.

c. If the initial board decision is adverse to the applicant after exhausting the administrative procedure under

subdivisions a and b, the applicant may file a request for a formal hearing to be conducted under North Dakota Century Code chapter 28-32. The request for a formal hearing must be filed within thirty days after notice of the initial decision has been mailed or delivered. If an appeal is not filed within the thirty-day period, the initial decision of the board is final. If a request for a formal hearing is timely filed, notice of the hearing must be served at least thirty days prior to the date set for the hearing. The board shall request appointment of an administrative law judge from the office of administrative hearings to conduct the hearing and make recommended findings of fact, conclusions of law, and order. The board shall either accept the administrative law judge's recommended findings of fact, conclusions of law, and order or adopt its own findings of fact, conclusions of law, and order. The applicant may under North Dakota Century Code section 28-32-15 appeal the final decision resulting from this procedure to the district court.

5. **Payment of annuity.** If awarded, the disability annuity is payable on, or retroactive to, the first day of the month following the member's termination from covered employment minus any early retirement benefits that have been paid.

6. **Redetermination and recertification.**

   a. A disabled annuitant's eligibility must be recertified eighteen months after the date the first check is issued and thereafter as specified by the medical consultant. The executive director may waive the necessity for a recertification, based on the recommendation of the medical consultant.

   b. The executive director will send a recertification form by certified mail with return receipt to the disabled annuitant to be completed and sent back to the office. If completed recertification has not been received by the recertification date set in the recertification request, benefits will be suspended effective the first of the month following that date. Benefits will be reinstated the first of the month following recertification by the medical consultant.

   c. The medical consultant may require the disabled annuitant to be reexamined by a doctor. The submission of medical reports by the annuitant, and the review of those reports by the board's medical consultant, may satisfy the reexamination requirement. Upon recertification, the disabled annuitant must be reimbursed up to four hundred dollars for the cost of the required reexamination if

deemed necessary by the medical consultant and the executive director.

d. The medical consultant will make the recertification decision. The decision may be appealed to the board within ninety days of receiving the written recertification decision.

e. Benefit payments must be suspended immediately upon notice received from the medical consultant that the annuitant does not meet recertification requirements. The executive director shall notify the annuitant of the suspension of benefits by certified mail and shall reinstate benefits back to date of suspension if the annuitant is subsequently found to meet recertification requirements.

f. If it is determined that the disability annuitant was not eligible for benefits during any time period when benefits were provided, the executive director may do all things necessary to recover the erroneously paid benefits.

History: Effective January 1, 1992; amended effective July 1, 1994; June 1, 1996.
General Authority: NDCC 54-52-17
Law Implemented: NDCC 54-52-17, 54-52-26

71-02-06-01. Conditions for return. The accumulated contributions of a member who terminates permanent employment:

1. Before accumulating five years of service credit shall be automatically refunded unless the member elects to remain in an inactive status.

2. After accumulating five years of service credit shall be refunded upon application filed with the executive director.

3. The termination date for purposes of processing an application for refund or rollover must be the last date for which a member receives salary except for a member who is on an approved leave of absence. For members who are paid salary in any month following actual separation from employment if the salary is received after the normal processing date, the termination date for purposes of processing the application must be the same date as the date that the last paycheck was issued as salary.

History: Amended effective November 1, 1990; June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-17

71-02-06-04. Contributions paid in a month other than month earned. Adjustments for the following may only be made for individuals who are within ten years of the earlier of age fifty-five or meeting the rule of eighty-eight:

1. Participating employers shall report bonuses paid when remitting the contribution associated with the bonus.

2. Bonuses paid by a participating employer will be prorated equally as actual compensation paid over the term of the intended bonus period.

3. Upon receiving notice, contributions received in a month other than the month earned will be assigned to the appropriate month.

History: Effective June 1, 1993; amended effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-05, 54-52-06

71-02-06-08. Retirement contributions for individuals working less than a forty-hour workweek. Retirement contributions must be made on wages paid to eligible employees who are regularly scheduled for less

than forty hours per week but work more than twenty hours per week at intermittent intervals.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-05, 54-52-06

71-02-06-09. Individual employee incentive payments. Individual employee incentive payments received under North Dakota Century Code section 54-06-24 or similar programs are not considered to be salary and are not subject to retirement contributions.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-01(19), 54-52-05, 54-52-06

71-02-08-02. Withdrawal. Any political subdivision may discontinue participation in the fund. if the following requirements are met:

1. The political subdivision must ~~first~~ provide the board with a copy of a resolution adopted by the governing authority authorizing ~~withdrawal--from--the--fund.--After-receiving-the resolution,-the-board-will-then-calculate,-with--the--help--of the--fund's-actuary,-the-amounts-to-be-deposited-with-the-fund to-provide-future-benefit-payments--for-those-who-are-eligible~~ the termination of participation in the fund.

2. Upon receiving a copy of the written resolution, an actuarial study must be done by the plan's actuary to determine the accrued benefit of all vested employees minus allocated assets from the date of participation. The interest assumption used must be the plan's interest assumption used for funding purposes.

3. Any costs incurred by the fund, resulting from a political subdivision ceasing participation, must be assessed against the political subdivision.

4. All employees of a political subdivision that has terminated participation in the fund must not be eligible for future benefit improvements granted to employees or former employees of participating governmental units after the date the employer's participation ceases.

5. An employee who is not vested at the time an employer ceases participation has the option of taking a refund or rollover of the employee's contribution plus interest.

History: Effective September 1, 1982; amended effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-02.1

71-02-08-03. Transfer of funds. Pursuant to subdivision e of subsection 13 of North Dakota Century Code section 15-10-17, funds may be transferred on behalf of those persons who are eligible through their employment with the state board of higher education. The following requirements apply:

1. Applicant must file a completed application for the teachers insurance and annuity association-college retirement equities fund.

2. Notice of termination and verification of teachers insurance and annuity association-college retirement equities fund eligibility must be filed by either the applicant or appropriate payroll officer.

3. Interest at the rate of seven percent must be used in calculating interest on the employer contribution, beginning from the date of first contribution through the date of transfer to the teachers' insurance and annuity association of America-college retirement equities fund.

History: Effective November 1, 1990; amended effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 15-10-17

71-02-08-05. Merger of eligible employer groups. If a merger between two or more eligible employer groups occurs, the following requirements apply:

1. Written notification must be provided to the office no later than sixty days before the merger is final.

2. When two or more employer groups merge into one, and all do not presently participate in the public employees retirement system, the units merging must decide upon one of the following:

   a. The participating employer or employers may elect to cease participation as of the date of the merger, subject to payment of any actuarial liabilities accrued. An actuarial study must be conducted at the cost of the exiting employer upon providing the public employees retirement system with written notice of the employer's election to cease participation.

   b. Subject to executing a revised participation agreement, eligible employees who have not previously participated shall be given the opportunity to participate or waive participation effective the date of the merger. Any person hired in an eligible position after the consolidation date must participate.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 15-10-17, 54-52-02.1

CHAPTER 71-02-09

71-02-09-01. Review procedure. A member who has received notice that the member's application for benefits has been denied in whole or in part may within ~~sixty~~ thirty days of receipt of such notice secure review by written request addressed to the board in care of the executive director of the public employees retirement system. ~~In connection with such a review, the~~ The applicant ~~shall have~~ has the right to all relevant information available to the board ~~which may be relevant to the applicant's review~~ and may submit arguments or comments in writing. The board ~~will~~ must render a decision ~~as soon as possible~~ and within one hundred twenty days after the request for a review is timely filed. The decision ~~will be~~ by the board must be submitted to the applicant in writing and ~~including~~ include the specific reason or reasons for the decision and the specific references to the provisions of the plan on which the decision is based~~, and such decision shall be final and binding on the applicant~~.

History: Amended effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-04

71-02-09-02. Formal review procedure. If the initial decision is adverse to the applicant after exhausting the administrative procedure under section 71-02-09-01, the applicant may file a request for a formal hearing to be conducted under North Dakota Century Code chapter 28-32. The request for a formal hearing must be filed within thirty days after notice of the initial decision has been mailed or delivered. If an appeal for a formal hearing is not filed within the thirty-day period, the initial decision of the board is final. If a request for a formal hearing is timely filed, notice of the hearing must be served at least thirty days prior to the date set for the hearing. The board shall request appointment of an administrative law judge from the office of administrative hearings to conduct the hearing and make recommended findings of fact, conclusions of law, and order. The board shall either accept the administrative law judge's recommended findings of fact, conclusions of law, and order or adopt its own findings of fact, conclusions of law, and order. The applicant may under North Dakota Century Code section 28-32-15 appeal the final decision resulting from this procedure to the district court.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-04

CHAPTER 71-03-03

71-03-03-01. Enrollment. ~~Eligible--employees--are~~ An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first thirty-one days of employment.

~~Eligible---employees--of--qualifying--political--subdivisions--are entitled-to-individual-coverage-provided-the-political-subdivision--with which-the-employee-is-employed-does-not-offer-a-group-health-plan.~~

History: Effective October 1, 1986; amended effective July 1, 1994; June 1, 1996.
General Authority: NDCC 54-52.1-08
Law Implemented: NDCC 54-52.1-03

71-03-03-02. Late enrollment. An eligible employee failing to submit an application for coverage within the first thirty-one days of employment must furnish evidence of insurability on ~~self~~ the employee and any ~~dependents~~ dependent for whom coverage is ~~later~~ desired. Any ~~or all~~ person may be denied coverage based on the carrier's underwriting requirements.

History: Effective October 1, 1986; amended effective June 1, 1996.
General Authority: NDCC 54-52.1-08
Law Implemented: NDCC 54-52.1-03

71-03-03-03. Early enrollment. ~~An-eligible-employee-may-obtain health-coverage-for-the-first-month-of-employment-by-making--application for--coverage--within--the--first--ten--working--days--of-employment-and submitting--the--full--amount--of--the--premium--with--the--application.~~ Repealed effective June 1, 1996.

History: ~~Effective-October-1,-1986.~~
General Authority: ~~ND66-54-52.1-08~~
Law Implemented: ~~ND66-54-52.1-03~~

71-03-03-04. Open enrollment. ~~Periodically,-at-a-time-set-by-the board,-eligible--employees--will--be--given--an--opportunity--to--obtain coverage--or--change-levels-of-coverage-without-need-to-furnish-evidence of-insurability.--Application-for-change-in-coverage-must--be--submitted during-the-time-established.~~ Repealed effective June 1, 1996.

History: ~~Effective-October-1,-1986.~~
General Authority: ~~ND66-54-52.1-08~~
Law Implemented: ~~ND66-54-52.1-03~~

71-03-03-05. ~~Enrollment~~ Open enrollment for ~~retirees~~ certain qualifying events. An eligible employee ~~who retires and~~, retiree, or surviving spouse who elects to take a monthly retirement benefit from the North Dakota public employees retirement system, North Dakota highway patrolmen's retirement system, the retirement system established by job service North Dakota, the teachers' fund for retirement, or teachers' insurance and annuity association of America-college retirement equities fund is eligible for coverage with the group health insurance program.

1. The employee, retiree, or surviving spouse must submit application for coverage within thirty-one days ~~of the~~ from one of the following qualifying events:

   a. The month in which the ~~member~~ eligible employee or retiree turns age sixty-five or becomes eligible for medicare; ~~the~~.

   b. The month in which the ~~member's~~ eligible employee's or retiree's spouse turns age sixty-five or becomes eligible for medicare; ~~the~~.

   c. The month in which the ~~member~~ eligible employee terminates employment; ~~the~~.

   d. The month in which the ~~member~~ eligible retiree or surviving spouse receives the first ~~qualified~~ monthly retirement benefit from one of the eligible retirement systems outlined ~~in subsection 3; the month in which the member's spouse receives the first qualified monthly benefit from one of the eligible retirement systems outlined in subsection 3;~~ the above.

   e. The month in which an eligible employee or retiree who is covered through a spouse's plan becomes ineligible for the spouse's plan due to divorce, death, loss of employment, reduction in hours or other events which may cause loss of coverage as determined by the board; ~~or~~ the.

   f. The month in which the ~~retiring member or spouse~~ eligible employee or retiree is no longer eligible for employer sponsored insurance, including coverage provided under the Consolidated Omnibus Budget Reconciliation Act.

2. Coverage will become effective on the first day of the month following the month in which the qualifying event ~~took place~~ occurred. If ~~the~~ an application is not submitted on time and subsequent coverage is desired, the eligible employee or retiree must submit evidence of insurability and coverage may be denied. If coverage is accepted, coverage will become effective on the first day of the month following approval by the carrier.

~~1.~~ 3. ~~Individuals~~ Other individuals eligible for the health insurance plan~~,--regardless--of--interruption---of---coverage~~ include~~:~~

~~a.--A--retired--employee-receiving-a-retirement-allowance-from the--public---employees---retirement---system,---travelers retirement---system---of--job--service--of--North--Dakota, teachers'-fund-for-retirement,-or-teachers--insurance--and annuity-association-college-retirement-equities-fund.~~

~~b.--A--surviving--spouse-receiving-a-retirement-allowance-from the--public---employees---retirement---system,---travelers retirement---system---of--job--service--of--North--Dakota, teachers'-fund-for-retirement,-or-teachers--insurance--and annuity-association-college-retirement-equities-fund.~~

~~c.--Deferred-retirees-and-their-spouses.~~

~~2.--A~~ a surviving spouse who is not receiving a ~~retirement allowance,--but--whose--spouse--had--received---a---retirement allowance---from---the--public--employees--retirement--system, travelers-retirement-system-of-job-service--of--North--Dakota, teachers'--fund--for--retirement,--or--teachers--insurance-and annuity-association-college-retirement-equities-fund,-will--be eligible--for--the--health--plan,--provided,~~ qualified monthly retirement benefit from one of the eligible retirement systems outlined above, but who was a covered dependent on the eligible retiree's group health insurance plan at the time of the eligible retiree's death, if there is no ~~interruption-of~~ lapse in coverage.

~~3.~~ 4. Individuals not eligible for the group health insurance plan include:

a. A ~~terminated~~ former employee who received a refund of the employee's retirement account.

b. A nonspouse beneficiary (eligible for Consolidated Omnibus Budget Reconciliation Act).

c. A deferred retiree or surviving spouse between the time in which the retiree or surviving spouse's eligibility for the Consolidated Omnibus Budget Reconciliation Act (if eligible) ends and the month in which the eligible retiree or surviving spouse receives the first monthly retirement benefit from one of the eligible retirement systems.

d. A formerly deferred retiree who received a refund of ~~his or her~~ the retiree's retirement account.

e. A surviving spouse of a nonvested employee eligible for the Consolidated Omnibus Budget Reconciliation Act.

f. A surviving spouse of a former employee who received a refund of the employee's retirement account.

History: Effective October 1, 1986; amended effective November 1, 1990; July 1, 1994; June 1, 1996.
General Authority: NDCC 54-52.1-08
Law Implemented: NDCC 54-52.1-03

71-03-03-06. Continuation of hospital and medical ~~coverages~~ coverage after termination. An employee who terminates employment and is not receiving a monthly retirement benefit from one of the eligible retirement systems, and applies for continued hospital and medical ~~coverages~~ coverage with the group health plan may continue such ~~coverages by remitting timely payments to the board~~ coverage for a maximum of eighteen months by remitting timely payments to the board. The employee desiring coverage shall notify the board within sixty days of the termination. Coverage will become effective on the first day of the month following the last day of coverage by the employing agency, ~~provided~~ if an application is submitted ~~in a timely manner~~ within sixty days. An individual who fails to timely notify the board ~~within the sixty days, and who desires subsequent coverage, will~~ is not be eligible for coverage.

History: Effective October 1, 1986; amended effective November 1, 1990; June 1, 1996.
General Authority: NDCC 54-52.1-08
Law Implemented: Consolidated Omnibus Budget Reconciliation Act (Pub. L. 99-272; 100 Stat. 222; 26 U.S.C. 162 et seq.)

71-03-03-08. Continuation of life insurance after retirement. An employee who is enrolled in the group life insurance program may continue the basic ~~one thousand dollar~~ life insurance coverage upon retirement or disability if the employee is entitled to a retirement allowance from an ~~agency~~ eligible retirement system by making application and remitting timely payments to the board.

History: Effective October 1, 1986; amended effective June 1, 1996.
General Authority: NDCC 54-52.1-08
Law Implemented: NDCC 54-52.1-03

71-03-03-09. Leave without pay. An employee on an approved leave without pay may elect to continue coverage for the periods specified in the plans for life insurance, hospital and medical coverages by paying the full premium to the agency. An employee electing not to continue coverage during a leave of absence must furnish evidence of insurability upon returning to work.

~~In the event an employee is on an approved leave without pay during an open enrollment period and new coverage is selected, such~~

~~coverage would not be effective until the first day the employee returns to work.~~

History: Effective October 1, 1986; amended effective November 1, 1990; June 1, 1996.
General Authority: NDCC 54-52.1-08
Law Implemented: NDCC 54-52.1-03

71-03-04-06. Minimum requirements for political subdivisions. An eligible political subdivision may extend the benefits of the group insurance program to its eligible employees subject to minimum requirements established by the board and a minimum period of participation of sixty months. If the political subdivision withdraws from participation before completing sixty months of participation, the political subdivision shall make payment to the board equal to the expenses incurred on behalf of that entity's employees which exceed the income received by the board on behalf of that entity's employees during the time of participation.

For purposes of this section:

1. "Expenses incurred" means:

   a. Claims incurred by the political subdivision during the enrolled period and paid during or within three months after the enrolled period and includes capitated payments to providers;

   b. Reasonable administrative expenses as incurred by the public employees retirement system and the claims administrator as set forth in the master contract; and

   c. The cost of any premium buy-down provided.

2. "Income received" means all premiums paid by the political subdivision.

Payment is due within three months of notice from the executive director, unless an alternative payment schedule has been approved by the board. Late payment will be assessed five and one-half percent per annum higher than the current cost of money as reflected by the average rate of interest payable on United States treasury bills maturing in six months in effect for North Dakota for the six months immediately prior to the month of deficiency. Repealed effective June 1, 1996.

History: Effective July 1, 1994.
General Authority: NDCC 54-52.1-03
Law Implemented: NDCC 54-52.1-03.1

STAFF COMMENT: Chapters 71-03-06 and 71-03-07 contain all new material but are not underscored so as to improve readability.

CHAPTER 71-03-06
PARTICIPATION OF POLITICAL SUBDIVISIONS EMPLOYEE RESPONSIBILITIES

71-03-06-01. Enrollment.

1. New eligible employees of a participating political subdivision are entitled to coverage the first of the month following the month of employment, if the employee submits an application for coverage within the first thirty-one days of employment.

2. Eligible employees of qualifying political subdivisions are entitled to individual coverage, subject to evidence of insurability if the political subdivision for which the employee works does not offer its employees a group health insurance plan.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52.1-03.1, 54-52.1-03.4

71-03-06-02. Late enrollment. An eligible employee failing to submit an application for coverage within the first thirty-one days of employment must furnish evidence of insurability for the employee and any dependents for whom coverage is desired. Any person may be denied coverage based on the carrier's underwriting requirements.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-06-03. Open enrollment for certain qualifying events. Political subdivisions must follow the same enrollment procedures as outlined in section 71-03-03-05.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-06-04. Continuation of hospital and medical coverages after termination. Political subdivisions must follow the same continuation procedure as outlined in section 71-03-03-06.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-06-05. Continuation of health benefits for dependents. A dependent of an employee with family coverage may continue coverage with the group after the dependent's eligibility would ordinarily cease. An employee's dependent, including a divorced or widowed spouse or children no longer dependent on the employee, may continue with the group after the dependent's eligibility would ordinarily cease. Coverage is limited to a period of thirty-six months and must be discontinued if the payment of the premium is not made in a timely manner. Dependents must notify the retirement board within sixty days of the qualifying event and submit an application in a timely manner. An individual who fails to submit an application to the retirement board within the sixty days is not eligible for coverage.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-06-06. Continuation of life insurance after retirement. Political subdivisions must follow the same continuation procedure as outlined in section 71-03-03-08.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-06-07. Leave without pay. Political subdivisions must follow the same leave without pay procedures as outlined in section 71-03-03-09.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-06-08. Employee contribution. An employee who is enrolled in the group insurance plan and required by the employing agency to pay a part of the premium must pay the amount due to the employing agency in advance of the employer's payment to the public employees retirement system. The employee's contribution may be paid by payroll deduction or any other method acceptable to the agency.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-02, 54-52.1-03.1

CHAPTER 71-03-07
PARTICIPATION OF POLITICAL SUBDIVISIONS EMPLOYER RESPONSIBILITIES

71-03-07-01. Employer contribution. Each employer must submit to the board the full monthly premium amount for each eligible employee enrolled in the group insurance plan. The employer must verify the number of eligible employees and the level of coverage for each. An employee's coverage must end the month after termination of employment. When an employee transfers from one enrolled employer to another, the new employer is responsible for submitting the premium for the first of the month following employment.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03.1

71-03-07-02. Information to employee. Each employer shall inform each eligible employee of the employee's right to group insurance and the process necessary to enroll. The employer shall provide each eligible employee such forms as necessary to enroll in the group insurance program.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-07-03. Collecting employee contributions. Each employer shall collect any employee contribution due and submit it with any employer contribution to the retirement board each month. When an employee on an approved leave of absence requests to continue in the group, the employer shall collect the full amount of the premium from the employee each month and remit it to the retirement board. Each employer shall determine the amount of employee contributions, however,

the level of contribution must be consistently applied to all eligible employees.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-07-04. Termination of employment. Each employer shall notify the retirement board when an eligible employee terminates employment. The retirement board shall inform the terminating employee of options available to the employee for continuation of coverage.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-03, 54-52.1-03.1

71-03-07-05. Premium for basic term life insurance. A political subdivision that elects to participate in the group life insurance program shall pay to the retirement board the full premium for the basic term life insurance for each of its eligible employees.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-02, 54-52.1-03.1

71-03-07-06. Requirements for enrolling paid members of political subdivision boards, commissions, or associations. Each employer shall inform the paid members of its board, commission, or association of their right to the group insurance plan and the process necessary to enroll. Each employer shall provide each eligible member such forms as necessary to enroll in the group insurance plan. Each employer shall collect any member contribution due and submit it along with any employer contribution to the retirement board each month. The board, commission, or association shall determine the amount of employer contribution. The employer contribution may be any amount equal to or less than the amount determined for eligible employees but may not exceed the employer contribution for eligible employees. Each employer shall notify the retirement board when an eligible member is no longer eligible for the group insurance plan. The retirement board shall inform such member of options available for continuation of coverage.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-02, 54-52.1-03, 54-52.1-03.1

71-03-07-07. Minimum requirements for political subdivisions. An enrolled political subdivision must extend the benefits of the group insurance program to its eligible employees and paid members of its board, commission, or association subject to minimum requirements

established by the retirement board and a minimum period of participation of sixty months. If the political subdivision withdraws from participation before completing sixty months of participation, the political subdivision must make payment to the retirement board equal to the expenses incurred on behalf of that political subdivision's employees which exceed the income received by the retirement board on behalf of that political subdivision's employees during the time of participation. For purposes of this section:

1. "Expenses incurred" means:

   a. Claims incurred by the political subdivision during the enrolled period and paid during or within three months after the enrolled period and includes capitated payments to providers;

   b. Reasonable administrative expenses as incurred by the public employees retirement system and the claims administrator as set forth in the master contract; and

   c. The cost of any premium buy-down provided.

2. "Income received" means all premiums paid by the political subdivision to the retirement board.

Full payment is due within three months after receipt of notice from the executive director, unless an alternative payment schedule has been approved by the retirement board. A late payment charge must be assessed on all money due on an account at a rate of one and three-fourths percent per month.

History: Effective June 1, 1996.
General Authority: NDCC 54-52-04, 54-52.1-03.1
Law Implemented: NDCC 54-52.1-02, 54-52.1-03, 54-52.1-03.1

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71-04-05-01. Employer enrollment. Any employer may extend the benefits of the deferred compensation plan to its employees by agreeing to abide by the deferred compensation plan, rules developed by the retirement board, executing an administrative agreement and submitting a ~~certified~~ signed copy of meeting minutes to the employers' governing board, wherein the governing board has appointed the retirement board to administer its deferred compensation plan.

History: Effective April 1, 1989; amended effective June 1, 1996.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 54-52.2-03

71-04-07-05. Beneficiary benefits before commencement of payments. If the participant dies before distribution of the participant's account has commenced, or separates from service and dies before payments have begun, the entire interest of the participant's account will be distributed to the participant's designated beneficiary. Any distributions payable for more than one year must be in substantially nonincreasing amounts. If the designated beneficiary is the surviving spouse, distributions must commence no later than December thirty-first of the year thereafter unless the surviving spouse irrevocably elects to defer distribution to a future date; however, a distribution can be deferred no later than April first of the calendar year following the year in which the participant would have attained age seventy and one-half. Benefits must be paid for a period not to exceed the life expectancy of the surviving spouse.

If the designated beneficiary is not the spouse, distribution must commence no later than December thirty-first of the year following the year of the participant's death and must be made within a time period not to exceed fifteen years.

If the participant's designated beneficiary dies before the account has been distributed to the beneficiary, the unpaid balance will be paid as a lump sum to the beneficiary's estate.

History: Effective April 1, 1989; amended effective July 1, 1994; June 1, 1996.
General Authority: NDCC 28-32-02, 54-52.2-03.2
Law Implemented: NDCC 54-52.2-03

71-04-07-06. Beneficiary benefits after commencement of payments. If the participant dies after distribution of the participant's account has commenced, the remaining account balance will be distributed to the participant's designated beneficiary. Benefits must continue at least as rapidly as the method selected by the participant before death. Distributions to a nonspouse beneficiary must be made in a time period not to exceed fifteen years.

If the participant's designated beneficiary dies before the account has been distributed to the beneficiary, the unpaid balance will be paid as a lump sum to the beneficiary's estate.

History: Effective July 1, 1994; amended effective June 1, 1996.
General Authority: NDCC 28-32-02, 54-52.2-03.2
Law Implemented: NDCC 54-52.2-03

71-05-02-02. Determination of disability - Procedures.

1. **Application.**

   a. Application for disability benefits must be made within one year from the last date of covered employment on the form provided by the plan administrator.

   b. If the member is unable or unwilling to file an application, the member's employer or legal representative may file the member's disability application.

   c. The application must explain the cause of the disability, the limitations caused by the disability, the treatment being followed, and the effect of the disability on the individual's ability to be engaged in any gainful occupation for which the person is, or could become, reasonably fitted by education, training, or experience.

2. **Medical examination.**

   a. The applicant for disability retirement must provide the plan administrator with medical examination reports.

   b. An initial medical examination should be completed by the member's attending or family physician on the medical examination form provided by the plan administrator. If deemed necessary by the board's medical consultant, an additional examination must be completed by a specialist in the disability involved. Available medical or hospital reports may be accepted in lieu of a medical examination report if deemed acceptable by the medical consultant.

   c. The member is liable for any costs incurred by the member in undergoing medical examinations and completing and submitting the necessary medical examination reports, medical reports, and hospital reports.

3. **Medical consultant.**

   a. The board will retain a medical doctor to act as its consultant on disability retirement applications.

   b. The medical consultant shall review all medical information provided by the applicant.

   c. The medical consultant will be responsible to advise the plan administrator of the medical diagnosis and whether the condition is a permanent and total disability.

4. **Decision.**

   a. The plan administrator shall consider applications for disability benefits and shall make a written decision whether an applicant is entitled to benefits. The decision must be mailed to the applicant's address of record.

   b. The applicant may appeal an adverse determination to the board by providing a written notice of appeal within ~~sixty~~ thirty days of the date that the plan administrator mailed the decision.

   c. The board shall consider all appeals at regularly scheduled board meetings. The applicant must be notified of the time and date of the meeting and may attend ~~or~~ and be represented by legal counsel. The ~~plan--administrator~~ executive director shall provide to the board for its consideration a case history brief that includes membership history, medical examination summary, and the ~~medical-consultant's~~ plan administrator's conclusions and recommendations. The board shall make the determination for eligibility at the meeting unless additional evidence or information is needed. The discussion concerning disability applications must be confidential and closed to the general public.

   d. If the initial board decision is adverse to the applicant, after exhausting the administrative procedure under subdivisions b and c, the applicant may file a request for a formal hearing to be conducted under North Dakota Century Code chapter 28-32. The request for a formal hearing must be filed within thirty days after notice of the initial decision has been mailed or delivered. If an appeal is not filed within the thirty-day period the initial decision of the board is final. If a request for a formal hearing is timely filed, notice of the hearing must be served at least thirty days prior to the date set for the hearing. The board shall request appointment of an administrative law judge from the office of administrative hearings to conduct the hearing and make recommended findings of fact, conclusions of law, and order or adopt its own findings of fact, conclusions of law, and order. The applicant may under North Dakota Century Code section 28-32-15 appeal the final decision resulting from this procedure to the district court.

5. **Payment of annuity.** If awarded, the disability annuity is payable on, or retroactive to, the first day of the month following the member's termination from covered employment.

6. **Redetermination and recertification.**

a. A disabled annuitant's eligibility must be recertified on July first following the second anniversary date of disability retirement. An additional recertification is required on July first five years thereafter. The plan administrator may require additional recertifications, or waive the necessity for a recertification, if the facts warrant this action.

b. The plan administrator will send a recertification form to the disabled annuitant to be completed and sent back to the fund.

c. The plan administrator may require the disabled annuitant to be reexamined by a doctor at the annuitant's own expense. The submission of medical reports by the member, and the review of those reports by the board's medical consultant, may satisfy the reexamination requirement.

d. The plan administrator will make the recertification decision and bring the matter to the board only if warranted.

e. If it is determined that the disability annuitant was not eligible for benefits during any time period when benefits were provided, the plan administrator may do all things necessary to recover the erroneously paid benefits.

History: Effective November 1, 1990; amended effective June 1, 1992; June 1, 1996.
General Authority: NDCC 39-03.1-06, 39-03.1-11
Law Implemented: NDCC 39-03.1-11

71-05-02-03. Aggrieved parties' rights. ~~Any applicant aggrieved by a decision of the board may initiate a formal administrative action against the board in accordance with North Dakota Century Code chapter 28-32 (Administrative Agencies Practice Act). The board shall request appointment of an independent hearing officer from the attorney general's office to officiate the hearing and make findings of fact, conclusions of law, and order. The applicant may appeal the final decision resulting from this proceedure to the district court in accordance with the Administrative Agencies Practice Act.~~ Repealed effective June 1, 1996.

~~**History:** Effective November 1, 1990.~~
~~**General Authority:** NDCC 39-03.1-06, 39-03.1-11~~
~~**Law Implemented:** NDCC 39-03.1-11~~

71-05-04-03. Repurchase of service credit and purchase of additional service credit.

~~1.--A--contributor--may--purchase--service--credit--for-time-spent serving-as-a-member-of-the-legislative-assembly.--An--eligible contributor--must-submit-a-completed-purchase-application-(SFN 17758)-along-with-purchase-amount-within-one--year--after--the adjournment-of-that-legislative-session.~~

~~2.--Upon--reemployment,--a--contributor--who-previously-received-a refund-may-repurchase-service-credit.--A-completed--repurchase agreement--(SFN--17758)--must-be-submitted-to-the-board-within ninety-days-of-reemployment.~~ To purchase additional credit or repurchase past service, a contributor or participating member of an alternative retirement system must notify the public employees retirement system, in writing, of the service for which the person wishes to receive credit. If the contributor is purchasing legislative service credit, a written request must be received from the contributor within one year after the adjournment of that legislative session.

History: Effective October 1, 1991; amended effective June 1, 1996.
General Authority: NDCC 39-03.1-06, 39-03.1-10.1, 39-03.1-14.1
Law Implemented: NDCC 39-03.1-08.1~~;--38--USC--2021-2026~~, 39-03.1-10.1, 39-03.1-14.1

71-05-04-04. Payment. The total dollar amount for repurchase or purchase may be paid in a lump sum or on a monthly, quarterly, semiannual, or annual basis. Payments are subject to contribution limitations established under 26 U.S.C. 415. Payments must begin within ninety days of the date the written cost confirmation is prepared. If the installment method is used, the following conditions apply:

~~1.--The--cost--of--legislative--service--credit-must-be-calculated using-twenty-eight-percent-of-current-monthly-salary--at--time of--election-to-purchase-multiplied-by-the-number-of-months-to be-purchased.~~

~~2.--Payment--of--repurchase--of--service--must-be-calculated-using twenty-eight-percent-of-current--monthly--salary--at--time--of election--to-purchase-multiplied-by-the-number-of-months-to-be purchased.~~

~~3.--If--payment-is-made-on-an-installment-basis,-amount-is-subject to-an-interest-rate-established-by-the-board.---The--following conditions-also-apply:~~

a. 1. Simple interest at the actuarial rate of return ~~will~~ must accrue monthly on the unpaid balance. Interest is calculated from the fifteenth of each month.

~~b.--A--minimum-payment-of-fifty-dollars-per-month-is-required.~~

c. 2. The installment schedule ~~can be~~ may extend for a maximum term of ~~five~~ ten years or the number of years until the contributor meets normal retirement age, whichever is greater.

~~d.--There-is-no-penalty-for-early-payoff.~~

e. 3. Installment payments ~~can~~ may be made by a payroll deduction where available. However, it is the responsibility of the ~~member~~ contributor to initiate and terminate the payroll ~~reduction~~ deduction. ~~The-first-payment-is-due--within--ninety days--of--notice--by-the-public-employees-retirement-system-of the-total-amount--due--or--the--amount--due--pursuant--to--the installment-method-selected.~~

4. Payments are due by the fifteenth of the month to be credited for the month.

5. Payments may only be received from a contributor until the fifteenth of the month in which the contributor's last retirement contribution is received.

History: Effective October 1, 1991; amended effective June 1, 1996.
General Authority: NDCC 39-03.1-06, 39-03.1-08.1, 39-03.1-10.1, 39-03.1-14.1
Law Implemented: NDCC 39-03.1-08.1~~;--38--USC--2021-2026~~, 39-03.1-10.1, 39-03.1-14.1

71-05-04-04.1. Costs. The cost to repurchase service credit must be calculated by applying actuarial factors to the amount of the retirement and retiree health insurance credit being purchased by the contributor or member of an alternative retirement system. The contributor's current age, average salary as calculated under subsection 2 of North Dakota Century Code section 39-03.1-11, and current credited service on record with the North Dakota public employees retirement system in the month in which the contributor's written request is received must be used in the cost calculation. The amount of retirement and retiree health insurance credit benefits being purchased must be calculated using the benefit formulas in place at the time the written request is received from the contributor. When calculating the cost, enhancements to the benefit formula must be considered to be in place at the time the law is signed by the governor.

The retirement board must adopt actuarial assumptions necessary to determine the actuarial factors for the cost calculation. The assumptions must be reviewed concurrently with the assumptions for the retirement program.

Upon receipt of the written request from the contributor or member of an alternative retirement system, a written cost confirmation must be prepared and mailed to the individual. The cost stated in the confirmation letter is valid for a period of ninety days from the date of the letter.

History: Effective June 1, 1996.
General Authority: NDCC 39-03.1-06, 39-03.1-10.1, 39-03.1-14.1
Law Implemented: NDCC 39-03.1-08.1, 39-03.1-10.1, 39-03.1-14.1

71-05-04-05. Delinquent payment. If a payment to be made pursuant to section 71-05-04-04 is not received within thirty days of the due date, the ~~plan administrator~~ public employees retirement system shall send a letter to the ~~participating member~~ contributor or member of an alternative retirement system advising ~~them~~ the person of the delinquency. If no payment is received within sixty days after the due date, the account must be closed. Payments received on ~~any~~ a closed account ~~will~~ must be returned to the member.

History: Effective October 1, 1991; amended effective June 1, 1996.
General Authority: NDCC 39-03.1-06, 39-03.1-10.1, 39-03.1-14.1
Law Implemented: NDCC 39-03.1-08.1~~;--38--USC--2021-2026~~, 39-03.1-10.1, 39-03.1-14.1

71-05-04-06. Crediting purchased or repurchased service. Service purchased or repurchased will be credited in the following manner:

1. The ~~employee's~~ contributor's record ~~will~~ must be updated with the ~~benefit~~ additional service credit once the account is paid in full.

2. If the ~~member~~ contributor or member of an alternative retirement system terminates, retires, or the ~~member's~~ contributor's account is closed due to delinquency, service credit ~~will~~ shall be granted ~~in--proportion--to--the--actual payments~~ by taking the months of service credit being purchased times the percentage paid. The percentage is determined by taking the total payments made towards the purchase divided by the total amount to be paid over the term of the purchase. Fractions of service credit must be rounded to the nearest whole month.

History: Effective October 1, 1991; amended effective June 1, 1996.
General Authority: NDCC 39-03.1-06, 39-03.1-10.1, 39-03.1-14.1
Law Implemented: NDCC 39-03.1-08.1, 39-03.1-10.1~~;--38--USC-2021-2026~~, 39-03.1-14.1

71-05-04-08. Conversion of sick leave. To convert unused sick leave to service credit, the member must notify the office, in writing, of the amount of unused sick leave to be converted and the member's

employer must confirm the member's unused balance of accumulated sick leave as of the date the member terminates employment. One month of service credit must be awarded for each one hundred seventy-three and three-tenths hours of unused accumulated sick leave.

Payments may be accepted from the member as early as six months prior to termination if the following requirements are met:

1. A notice of termination or application for monthly benefits form is on file with the public employees retirement system.

2. A written certification by the member's employer, as to the member's unused balance of accumulated sick leave as of the date the member wishes to begin payment, is on file with the public employees retirement system.

3. The sick leave conversion payment must be within the contribution limits of 26 U.S.C. 415.

4. At termination, the sick leave conversion payment must be recalculated using the member's unused balance of accumulated sick leave, confirmed by the member's employer, and the member's final average salary as of that date.

5. If there is a difference between the sick leave conversion payment amount and the amount the member has paid, any overpayment must be refunded to the member and any underpayment must be collected from the member within sixty days of termination.

6. The member's record must be updated with the additional service credit once payment is made in full and the member has terminated employment.

History: Effective June 1, 1996.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-30

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71-05-05-08. Retirement - Dual membership. ~~In the event~~ If a member elects to begin drawing monthly benefits while continuing to participate in the North Dakota public employees retirement system or teachers' fund for retirement, ~~retirement calculations must be based upon salary earned in the employ of the highway patrol as a patrolman~~ the provisions of section 71-02-04-09 must apply.

History: Effective October 1, 1991; amended effective June 1, 1996.
General Authority: NDCC 39-03.1-14.1(1)(c)
Law Implemented: NDCC 39-03.1-14.1

71-06-01-01. Eligibility for ~~prefunded~~ retiree health insurance credit applied to **premiums for annuitants and surviving spouses under the North Dakota public employees retirement system, the North Dakota highway patrolmen's retirement system, the retired judges under North Dakota Century Code chapter 27-17, and annuitants of the ~~travelers~~** job service **retirement program.** All receiving members of the public employees retirement system, highway patrolmen's retirement system, judges retirement system, retired judges under North Dakota Century Code chapter 27-17, and annuitants of the ~~travelers~~ job service retirement program will be eligible for ~~prefunding of~~ retiree health credit applied to premiums that satisfy the enrollment requirements of section 71-03-03-05, with the exception of those receiving members who are receiving their benefit based on prior service credits rather than the defined benefits program. Vested members deferring benefits will not be eligible until payment of benefit commences.

History: Effective April 1, 1992; amended effective June 1, 1996.
General Authority: NDCC 54-52.1-03.2(b)
Law Implemented: NDCC 54-52.1-03.3

71-06-01-02. Calculation of ~~prefunded~~ retiree health insurance credit. ~~Prefunded~~ Retiree health insurance credit will be calculated on actual years and months of service, identical to retirement benefits.

1. ~~Prefunded~~ Retiree health insurance credit will be subject to reduction factors in the event of early retirement.

For annuitants of the public employees retirement system and North Dakota public employees retirement system judges:

Age at retirement	Reduction factor	Age at retirement	Reduction factor
64 to 65	3%	59 to 60	33%
63 to 64	9%	58 to 59	39%
62 to 63	15%	57 to 58	45%
61 to 62	21%	56 to 57	51%
60 to 61	27%	55 to 56	57%

For annuitants of the ~~travelers~~ job service retirement program:
{This includes those who retired under a discontinued service annuity but does not include those who retired at a normal or optional date.}

Age at retirement	Reduction factor	Age at retirement	Reduction factor	Age at retirement	Reduction factor
64 to 65	3%	59 to 60	33%	54 to 55	63%
63 to 64	9%	58 to 59	39%	53 to 54	69%
62 to 63	15%	57 to 58	45%	52 to 53	75%

61 to 62	21%	56 to 57	51%	51 to 52	81%
60 to 61	27%	55 to 56	57%	50 to 51	87%

For annuitants of the highway patrol fund and national guard security police and firefighters:

Age at retirement	Reduction factor
54 to 55	3%
53 to 54	9%
52 to 53	15%
51 to 52	21%
50 to 51	27%

2. Disabled annuitants receiving benefits under subdivision e of subsection 3 of North Dakota Century Code section 54-52-17, subdivision d of subsection 3 of North Dakota Century Code section 39-03.1-11, ~~or~~ North Dakota Century Code section 52-11-01, or section 71-02-05-05 will be eligible for full ~~prefunded~~ retiree health insurance credit benefits. No age reduction factor will be applied.

3. A surviving spouse eligible to receive benefits under subdivisions b and c of subsection 6 of North Dakota Century Code section 54-52-17, subdivisions b and c of subsection 6 of North Dakota Century Code section 39-03.1-11, or North Dakota Century Code section 52-11-01 will receive ~~prefunded~~ retiree health insurance credit based on the deceased member's years of service without any age reduction applied.

4. A surviving spouse receiving benefits under the provisions of subdivision a or c of subsection 9 of North Dakota Century Code section 54-52-17; subdivisions a, b, and c of subsection 5 of North Dakota Century Code section 27-17-01; subsection 9 of North Dakota Century Code section 39-03.1-11; or North Dakota Century Code section 52-11-01 will receive ~~prefunded~~ retiree health insurance credit for the duration benefits are paid, based upon the original annuitant's retirement age.

History: Effective April 1, 1992; amended effective June 1, 1996.
General Authority: NDCC 54-52.1-03.2(b)
Law Implemented: NDCC 54-52.1-03.3

71-06-01-03. For individuals receiving more than one benefit entitled to ~~prefunded~~ retiree health insurance credit.

1. If an individual is receiving more than one benefit from the public employees retirement system, or other participating system; one as a surviving spouse, and the other based upon their own service credit, the higher of the two ~~prefunded~~

retiree health insurance credits will be applied towards the individual's uniform group health insurance premium. Under no circumstances will these two benefits ~~to~~ be combined. If the surviving spouse benefit is the larger of the two benefits, and is limited in duration, the individual will be eligible to utilize his or her own ~~prefunded~~ retiree health insurance credit upon cessation of surviving spouse benefits.

2. If an individual is receiving a public employees retirement system retirement benefit as a surviving spouse and is also an active contributor to either the public employees retirement system, the highway patrol retirement system, the judges retirement system, or the ~~travelers~~ job service retirement program, the individual will not be eligible for ~~prefunded~~ retiree health insurance credit until one of the following events occurs:

   a. The individual terminates employment, at which time they may receive the ~~prefunded~~ retiree health insurance credit as any other surviving spouse.

   b. The individual retires and begins receiving a benefit through an eligible retirement system, at which time they may receive the greater of their own ~~prefunded~~ retiree health insurance credit or the credit available as a surviving spouse.

3. If the individual is employed by a political subdivision which does not participate in the public employees retirement system health plan, and is drawing a retirement benefit or a surviving spouse benefit, the individual may receive the ~~prefunded~~ retiree health insurance credit as any other annuitant based upon a retiree premium.

4. If a husband and wife are both participants of a retirement system that provides the ~~prefunded~~ retiree health insurance credit, and are both receiving a benefit, the ~~prefunded~~ retiree health insurance credit will be applied as follows:

   a. If each individual takes a single health insurance plan under the uniform group health insurance program, each will have their respective ~~prefunded~~ retiree health insurance credit applied to their respective premiums.

   b. If only one individual takes a family health plan under the uniform group health insurance program, only that individual will be able to utilize his or her ~~prefunded~~ retiree health insurance credit applied to the premium.

   c. In no event will the ~~prefunded~~ retiree health insurance credits for both spouses be combined and applied to only one premium.

5. Persons with service credit in more than one of the participating systems may combine that credit for ~~prefunded~~ retiree health insurance purposes.

History: Effective April 1, 1992; amended effective June 1, 1996.
General Authority: NDCC 54-52.1-03.2(b)
Law Implemented: NDCC 54-52.1-03.3

71-06-01-04. Employer paid health premiums. An individual can only receive ~~prefunded~~ retiree health insurance credit if they are responsible for paying their own health premium. If a previous employer or current employer is paying for a retired individual's health insurance premium, the employer cannot receive the benefit of the ~~prefunded~~ retiree health insurance credit. If this situation occurs, the ~~prefunded~~ retiree health insurance credit applicable to the annuitant will not be applied to the annuitant's health insurance premium until the annuitant begins paying the premium.

History: Effective April 1, 1992; amended effective June 1, 1996.
General Authority: NDCC 54-52.1-03.2(b)
Law Implemented: NDCC 54-52.1-03.3

71-06-01-05. Member contributions. Any member contribution received for purposes of ~~prefunding~~ retiree health insurance credit must be refunded without interest to any member who terminates employment and who receives a refund of retirement contributions.

History: Effective April 1, 1992; amended effective June 1, 1996.
General Authority: NDCC 54-52.1-03.2(b)
Law Implemented: NDCC 54-52.1-01(1c)

71-06-01-06. Erroneous crediting of the retiree health insurance credit. If an error occurs in granting retiree health insurance credit, the error shall be corrected the first of the month following discovery of the error in accordance with sections 71-02-04-10 and 71-02-04-11, except any underpayment of the retiree health insurance credit under this chapter must be credited to the maximum amount of the monthly premium payable each month until the amount of the underpayment has been credited.

History: Effective June 1, 1996.
General Authority: NDCC 54-52.1-03.2, 54-52.1-03.3
Law Implemented: NDCC 54-52.1-03.3, 54-52.1-03.3

TITLE 75

Department of Human Services

APRIL 1996

CHAPTER 75-04-05

AGENCY SYNOPSIS: Proposed amendments to North Dakota Administrative Code Chapter 75-04-05, Reimbursement for Providers of Services to Persons with Developmental Disabilities

A public hearing was conducted on August 3, 1995, in Bismarck, concerning proposed amendments to North Dakota Administrative Code Chapter 75-04-05, Reimbursement for Providers of Services to Persons with Developmental Disabilities, specifically subsection 2 of section 75-04-05-09, Rate Payments, subdivision a of subsection 3 of section 75-04-05-10, Reimbursement, and subsection 16 of section 75-04-05-13, Nonallowable Costs.

The rules clarify the authority of the department to approve budgets of providers of services to persons with developmental disabilities, based upon audited costs in prior periods rather than projected costs from prior periods.

75-04-05-09. Rate payments.

1. Except for intermediate care facilities for the mentally retarded, payment rate limits will be established for services, room, and board.

2. Interim rates based on factors including budgeted data, as approved, will be used for payment of services during the year.

3. Room and board charges to clients may not exceed the maximum supplemental security income payment less twenty-five dollars for the personal incidental expenses of the client, plus the average dollar value of food stamps to the eligible clientele in the facility. If the interim room and board rate exceeds the final room and board rate, the provider shall reimburse clients in a manner approved by the department.

4. In residential facilities where rental assistance is available to individual clients or the facility, the rate for room costs chargeable to individual clients will be established by the governmental unit providing the subsidy.

5. In residential facilities where energy assistance program benefits are available to individual clients or the facility, room and board rates will be reduced to reflect the average annual dollar value of such benefits.

6. Income from client production must be applied to client wages and the cost of production. The department will not participate in the gains or losses associated with client production conducted pursuant to the applicable provision of 29 CFR 525.

7. The final rate established is payment of all allowable, reasonable, and actual costs for all elements necessary to the delivery of a basic service to eligible clients subject to limitations and cost offsets of this chapter.

8. No payments may be solicited or received by a provider from a client or any other person to supplement the final rate of reimbursement.

9. The rate of reimbursement established must be no greater than the rate charged to a private payor for the same or similar service.

10. The department will determine interim and final rates of reimbursement for continuing contract providers based upon cost data from the:

    a. Submission requirements of section 75-04-05-02; and

    b. Field and desk audits.

11. Rates of continuing service providers, except for those identified in subdivision f of subsection 3 of section 75-04-05-10, will be based on the following:

    a. Rate for continuing contract providers, who have had no increase in the number of clients the provider is licensed to serve, will be based upon ninety-five percent of the

rated occupancy established by the department or actual occupancy, whichever is greater.

b. Rates for continuing service providers, who have an increase in the number of clients the provider is licensed to serve in an existing service, will be based upon:

(1) Subdivision a of subsection 11 of section 75-04-05-09 for the period until the increase takes effect; and

(2) Ninety-five percent of the projected units of service for the remaining period of the fiscal year based upon an approved plan of integration or actual occupancy, whichever is greater.

c. When establishing the final rates, the department may grant nonenforcement of subdivisions a and b of subsection 11 of section 75-04-05-09 when it determines the provider implemented cost containment measures consistent with the decrease in units, or when it determines that the failure to do so would have imposed a detriment to the well-being of its clients.

(1) Acceptable cost containment measures include a decrease in actual salary and fringe benefit costs from the approved salary and fringe benefits costs for the day service or group home proportionate to the decrease in units.

(2) Detriment to the well-being of clients includes a forced movement from one group home to another or obstructing the day service movement of a client in order to maintain the ninety-five percent rated occupancy requirement.

12. Adjustments and appeal procedures are as follows:

a. Rate adjustments may be made to correct errors.

b. A final adjustment will be made for those facilities which have terminated participation in the program and have disposed of all its depreciable assets. Federal medicare regulations pertaining to gains and losses on disposable assets will be applied.

c. Any requests for reconsideration of the rate must be submitted in writing to the developmental disabilities division within ten days of the date of the rate notification of the final rate determination. The department may redetermine the rate on its own motion.

d. A provider may appeal a decision within thirty days after mailing of the written notice of the decision on a request for reconsideration of the final rate.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 1995; April 1, 1996.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-16-10, 50-24.1-01

75-04-05-10. Reimbursement. Reported allowable costs will be included in determining the interim and final rate. The method of finalizing the reimbursement rate per unit will be through the use of the retrospective ratesetting system.

1. Retrospective ratesetting requires that an interim rate be established prior to the year in which it will be effective. The determination of a final rate for all services begins with the reported cost of the provider's operations for the previous fiscal year. Once it has been determined that reported costs are allowable, reasonable, and client-related, those costs are compared to the reimbursements received through the interim rate.

2. a. Settlements will be made through a recoupment or refund to the department for an overpayment, or an additional payment to the provider for an underpayment.

   b. Interprovider settlements between intermediate care facilities for the mentally retarded and day services will be made through a recoupment or refund to the department from the day service provider to correct an overpayment; or a payout to the intermediate care facilities for the mentally retarded, for the day service provider, to correct an underpayment.

3. Limitations.

   a. The department ~~will~~ shall accumulate and analyze statistics on costs incurred by providers. ~~These statistics~~ Statistics may be used to establish reasonable ceiling limitations for ~~efficiency-and-economy-based-on--a determination-of-the-standards-of-operations-necessary-for efficient-delivery-of~~ needed services. ~~These--limitations~~ Limitations may be established on the basis of cost of comparable facilities and services, or audited costs, and may be applied as ceilings on the overall costs, on the costs of providing services, or on the costs of specific areas of operations. The department may implement ~~such~~ ceilings at any time, based upon the statistics available, or as required by guidelines, regulations, rules, or statutes ~~concerning-title-XIX-of-the-Social-Security--Act~~.

b. Providers, to maintain reasonable rates of reimbursement, must deliver units of service at or near their rated capacity. Upon a finding by the department that an excess idle capacity exists and has existed, the cost of which is borne by the department, the provider will be notified of the department's intention to reduce the level of state financial participation or invoke the cancellation provisions of the provider agreement. The provider must, within ten days of such notification, demonstrate, to the satisfaction of the department, that the department should not invoke its authority under this provision, or accept the department's finding.

c. Providers will not be reimbursed for services, rendered to clients, which exceed the rated occupancy of any facility as established by a fire prevention authority.

d. Providers of residential services must offer services to each client three hundred sixty-five days per year, except for leap years in which three hundred sixty-six days must be offered. Costs and budget data must be reported on this basis and rates of reimbursement will be established on the same basis. Providers will not be reimbursed for those days in which services are not offered to clients.

e. Providers of day services must offer services to each client two hundred sixty days per year, except for leap years in which two hundred sixty-one days must be offered. Costs and budget data must be reported on this basis and rates of reimbursement will be established on the same basis. Providers will not be reimbursed for those days services are not offered to the clients. State recognized holidays will be treated as days in which services are offered.

f. Services exempted from the application of subdivisions d and e are:

   (1) Emergency services.

   (2) Infant development.

   (3) Family subsidy.

   (4) Supported living.

g. (1) Days of services in facilities subject to the application of subdivision d must be provided for a minimum of three hundred thirty-five days per year per client. A reduction of payment to the provider in an amount equal to the rate times the number of days of service less than the minimum will be made unless the regional developmental disability program

administrator determines that a failure to meet the minimum was justified.

(2) Days of services in facilities subject to the application of subdivision e must be provided for a minimum of two hundred forty days per year per client. A reduction of payment to the provider in an amount equal to the rate times the number of days of service less than the minimum will be made unless the regional developmental disability program administrator determines that a failure to meet the minimum was justified.

(3) For purposes of this subdivision, the fiscal year of the facility will be used, and all days before the admission, or after the discharge of the client will be counted toward meeting the minimum.

h. Salary and fringe benefit cost limits, governing the level of state financial participation, may be established by the department by calculating:

(1) Comparable salaries and benefits for comparable positions, by program size and numbers served, and programs in and out of state;

(2) Comparable salaries and benefits for comparable positions in state government;

(3) Comparable salaries and benefits for comparable positions in the community served by the provider; or

(4) Data from paragraphs 1, 2, and 3, taken in combination.

By using private funds, providers may establish higher salaries and benefit levels than those established by the department.

i. Management fees and costs may not exceed the lesser of two percent of administrative costs or the price of comparable services, facilities, or supplies purchased elsewhere, primarily in the local market.

History: Effective July 1, 1984; amended effective June 1, 1985; June 1, 1995; July 1, 1995; April 1, 1996.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-16-10, 50-24.1-01

75-04-05-13. Nonallowable costs. Nonallowable costs include:

1. Advertising to the general public exclusive of procurement of personnel and yellow page advertising limited to the information furnished in the white page listing.

2. Amortization of noncompetitive agreements.

3. Bad debt expense.

4. Barber and beautician services.

5. Basic research.

6. Capital improvements by the provider to the buildings of a lessor.

7. Compensation of officers, directors, or stockholders other than reasonable and actual expenses related to client services.

8. Concession and vending machine costs.

9. Contributions or charitable donations.

10. Corporate costs, such as organization costs, reorganization costs, and other costs not related to client services.

11. Costs for which payment is available from another primary third-party payor or for which the department determines that payment may lawfully be demanded from any source.

12. Costs of functions performed by clients in a residential setting which are typical of functions of any person living in their own home, such as keeping the home sanitary, performing ordinary chores, lawnmowing, laundry, cooking, and dishwashing. These activities shall be an integral element of an individual program plan consistent with the client's level of function.

13. Costs of participation in civic, charitable, or fraternal organizations.

14. Costs, including, by way of illustration and not by way of limitation, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to the vendor.

15. Costs incurred by the provider's subcontractors, or by the lessor of property which the provider leases, and which

becomes an element in the subcontractor's or lessor's charge to the provider, if such costs would have not been allowable under this section had they been incurred by a provider directly furnishing the subcontracted services, or owning the leased property.

16. Costs, exceeding the ~~amounts--budgeted--as--"salaries--and fringes",-"board-expenses",-"property--expenses",--"production expenses",--or--"other--costs",~~ approved budget unless the written prior approval of the department has been received.

17. Depreciation on assets acquired with federal or state grants.

18. Education costs incurred for the provision of services to clients who are, could be, or could have been, included in a student census. Education costs do not include costs incurred for a client, defined as a "child with disabilities" by subsection 2 of North Dakota Century Code section 15-59-01, who is no longer enrolled in a school district pursuant to an interdepartmental plan of transition.

19. Education or training costs, for provider staff, which exceed the provider's approved budget costs.

20. Employee benefits not offered to all full-time employees.

21. Entertainment costs.

22. Equipment costs for any equipment, whether owned or leased, not exclusively used by the facility except to the extent that the facility demonstrates to the satisfaction of the department that any particular use of the equipment was related to client services. Equipment used for client services, other than developmental disabilities contract services, will be allocated by time studies, mileage, client census, percentage of total operational costs, or otherwise as determined appropriate by the department.

23. Expense or liabilities established through or under threat of litigation against the state of North Dakota or any of its agencies; provided, that reasonable insurance expense shall not be limited by this subsection.

24. Federal and other governmental income taxes.

25. Fringe benefits exclusive of Federal Insurance Contributions Act, unemployment insurance, medical insurance, workers compensation, retirement, and other benefits which have received written prior approval of the department.

26. Fundraising costs, including salaries, advertising, promotional, or publicity costs incurred for such a purpose.

27. Funeral and cemetery expenses.

28. Goodwill.

29. Home office costs when unallowable if incurred by facilities in a chain organization.

30. Housekeeping staff or service costs.

31. In-state travel not directly related to industry conferences, state or federally sponsored activities, or client services.

32. Interest cost related to money borrowed for funding depreciation.

33. Items or services, such as telephone, television, and radio, located in a client's room and furnished primarily for the convenience of the clients.

34. Key man insurance.

35. Laboratory salaries and supplies.

36. Staff matriculation fees and fees associated with the granting of college credit.

37. Meals and food service in day service programs.

38. Membership fees or dues for professional organizations exceeding five hundred dollars in any fiscal year.

39. Miscellaneous expenses not related to client services.

40. Out-of-state travel expense which is not directly related to client services or which has not received written prior approval by the department.

41. a. Except as provided in subdivisions b and c, payments to members of the governing board of the provider, the governing board of a related organization, or families of members of those governing boards, including spouses and persons in the following relationship to those members or to spouses of those members: parent, stepparent, child, stepchild, grandparent, step-grandparent, grandchild, step-grandchild, brother, sister, half brother, half sister, stepbrother, and stepsister.

    b. Payments made to a member of the governing board of the provider to reimburse that member for allowable expenses incurred by that member in the conduct of the provider's business may be allowed.

c. Payments for a service or product unavailable from another source at a lower cost may be allowed except that this subdivision may not be construed to permit the employment of any person described in subdivision a.

42. Penalties, fines, and related interest and bank charges other than regular service charges.

43. Personal purchases.

44. Pharmacy salaries.

45. Physician and dentist salaries.

46. Production costs, such as the cost of the finished goods or products that are assembled, altered, or modified, square footage that the department determines is primarily for nontraining or production purposes, and property, equipment, supplies, and materials used in nonfacility-based day and work activity.

47. Religious salaries, space, and supplies.

48. Room and board costs in residential services other than an intermediate care facility for the mentally retarded, except when such costs are incurred on behalf of persons who have been found not to be disabled by the social security administration, but who are certified by the department as indigent and appropriately placed. Allowable room and board cost must not exceed the room and board rate established pursuant to subsections 2 and 3 of section 75-04-05-09. Services offering room and board temporarily, to access medical care, vocational evaluation, respite care, or similar time limited purposes are or may be exempt from the effect of this provision.

49. Salary costs of employees determined by the department to be inadequately trained to assume assigned responsibilities, but where an election has been made to not participate in appropriate training approved by the department.

50. Salary costs of employees who fail to meet the functional competency standards established or approved by the department.

51. Travel of clients visiting relatives or acquaintances in or out of state.

52. Travel expenses in excess of state allowances.

53. Undocumented expenditures.

54. Value of donated goods or services.

55. Vehicle and aircraft costs not directly related to provider business or client services.

56. X-ray salaries and supplies.

History: Effective July 1, 1984; amended effective June 1, 1985; January 1, 1989; August 1, 1992; June 1, 1995; July 1, 1995; April 1, 1996.
General Authority: NDCC 25-01.2-18, 50-06-16
Law Implemented: NDCC 25-16-10, 50-24.1-01

MAY 1996

CHAPTER 75-03-24

[Reserved]

CHAPTER 75-03-25

[Reserved]

STAFF COMMENT: Chapter 75-03-26 contains all new material and is not underscored so as to improve readability.

AGENCY SYNOPSIS: Regarding proposed new North Dakota Administrative Code Chapter 75-02-26, Aging Services Community Programs Under the Older Americans Act.

A public hearing was conducted on October 3, 1995, and on January 8, 1996, in Bismarck concerning proposed new North Dakota Administrative Code Chapter 75-03-26, Aging Services Community Programs Under the Older Americans Act.

The purpose of chapter 75-03-26 is to facilitate the implementation of community programs under the Older Americans Act. North Dakota required additional regulations for the equitable and economic administration of programs under the federal act.

The department proposed rules amending North Dakota Administrative Code chapter 75-03-26, Aging Services Community Programs Under the Older Americans Act, and conducted a public hearing on those rules on October 3, 1995, and on January 8, 1996, and received written comment on those proposed rules until the end of the day on Monday, November 6, 1995, and Friday, February 9, 1996.

CHAPTER 75-03-26
AGING SERVICES COMMUNITY PROGRAMS UNDER THE OLDER AMERICANS ACT

75-03-26-01. Definitions.

1. "Assessment" means an evaluation or examination of an older individual's situation to identify service needs.

2. "Chore service" means assistance with completing one-time occasional home tasks, including heavy housework, seasonal cleaning, minor home repair, and yard and walk maintenance.

3. "Comprehensive health maintenance program" means a combination of services provided in an effort to determine and maintain the health and well-being of participants, which includes monitoring and screening procedures for early detection of disease processes, health education, referral, and followup.

4. "Congregate meal" means a meal provided to an eligible individual in a group setting which provides at least one-third of the recommended daily nutritional requirement.

5. "Equipment" means tangible personal property having a useful life of more than two years and an acquisition cost of five hundred dollars or more per unit.

6. "Escort or shopping assistance service" means assistance for an older individual in securing services outside the individual's home environment.

7. "Frail disabled" means having a physical or mental disability, including Alzheimer's disease or a related disorder with

neurological or organic brain dysfunction, which restricts the ability of an individual to perform normal daily tasks or which threatens the capacity of an individual to live independently.

8. "Minority elderly" means an individual sixty years of age or over who is either American Indian, Alaskan native, Asian, Pacific islander, black, not of Hispanic origin, or Hispanic.

9. "Nutrition program" means a service that provides meals to an eligible individual in a congregate or a home setting that meets specific requirements.

10. "Older individual" means an individual who is sixty years of age or over.

11. "Outreach service" means seeking out older individuals, identifying the individual's service needs, and providing information and assistance in linking the individual with services that address the individual's identified need.

12. "Rural" means an area with a population of two thousand five hundred or less.

13. "Service provider" means any entity receiving funds under the Older Americans Act.

14. "Service recipient" means any individual receiving services under the Older Americans Act.

15. "Transportation service" means a service that provides a method of travel from one specific location to another specific location.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-02. Service provider management and assurances. All service providers shall:

1. Maintain the number of qualified staff needed to complete the program objectives and meet all grant or contract requirements;

2. Use generally accepted accounting procedures;

3. Report in the form and manner prescribed by the department;

4. Document the receipt and expenditure of cash-in-lieu of commodities;

5. Adhere to the department travel and per diem reimbursement rate;

6. Develop a procedure for service recipients to file and resolve grievances involving services and personnel;

7. Maintain and provide for the security of recipient specific information to include rural, frail-disabled, low income, and low-income minority;

8. Comply with departmental, contract, and grant rules, policies, and procedures;

9. Analyze and comment on local regulations and policies which affect an older individual;

10. Advocate for the development of a comprehensive and coordinated community-based system designed to assist an older individual in leading independent, meaningful, and dignified lives; and

11. Carry liability insurance for bodily injury and property damage for clients, staff, volunteers, vehicles, and facilities involved in the provision of services.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-03. Confidentiality. No information about an older individual, or obtained from an older individual by a service provider, may be disclosed in a form that identifies the individual without the written consent of the individual.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-04. Service recipient input. A service provider shall have formal written procedures for receiving input on current and needed services from older individuals.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-05. Training. Service providers shall provide or make available training to volunteers and paid personnel concerning the provision of services to older individuals. Service providers shall

attend training required by the division that addresses the needs or activities of the funded project.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-06. Equipment - Transfer of. The department reserves the right to transfer any equipment having a unit acquisition cost of one thousand dollars or more, including title, if the project or program for which the equipment was acquired is transferred to another federally funded project. The purpose of transferring the equipment to the new project must be for continued use in the project or program. Equipment purchased with federal fund cost share must be inventoried or transferred in accordance with 45 CFR part 74.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-07. Records retention.

1. Service providers shall retain records for three years from the day the department submits its last expenditure report to the federal government for that period from which the project received federal funds or when a federal audit has been completed on the time covered by the funding period. The department shall notify the project when the final expenditure report is submitted. The retention period is not terminated if an open or unresolved audit of those funds exists.

2. Records for senior center acquisition must be maintained for ten years following the acquisition.

3. Records for senior center construction must be retained for twenty years following the completion of the project.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-08. Access to records. An authorized representative of the department or federal government shall have the right of access, during normal office operating hours, to any books, documents, papers, or other records which are pertinent to the federal grant or contract,

in order to make audit, examination, excerpts, and transcripts. The right of access exists during the period that records are retained.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-09. Chore service program standard. Chore service seeks to maximize the independent functioning of an individual who has no one, such as relatives, to help the individual with heavy household chores.

1. An individual eligible for chore services is age sixty and over, is in greatest need with preference to low-income minority individuals, and is unable to perform heavy household tasks. Determination of need is made and documented by completion of the service recipient assessment in the form and manner prescribed by the department.

2. The chore service provider shall furnish the service in the older individual's home or rental unit if the residential arrangement does not already include any or all of these services.

3. The service provider shall furnish all equipment and tools needed to provide chore services, including ladders, rakes, lawnmowers, hammers, paintbrushes, snowblowers, and shovels.

4. The service recipient shall be responsible for the purchase and cost of consumable supplies used in the process of repair or maintenance, including soap, paper towels, garbage bags, and paint. Subject to the availability of federal funding, the department may provide materials for permanent fixtures, including grab bars in the tub or near the toilet, handrails, or ramps up to a maximum of one hundred fifty dollars expenditure per household.

5. Chore service providers are prohibited from performing the following service activities:

   a. Providing electrical, plumbing, or contractor services which require a licensed electrician, plumber, or contractor, unless these services are provided by a licensed electrician, plumber, or contractor;

   b. Providing major renovation and construction services;

   c. Providing chore services at the service recipient's commercial property; and

d. Services already provided by other service agencies, such as homemaker services.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16, 50-06.2-03, 50-24.5-02

75-03-26-10. Escort and shopping assistance program standard. Escort and shopping assistance program assists older individuals in securing services outside the individual's home environment and maximizes the older individual's ability to remain in the home environment as long as possible by helping older individuals to secure necessary services.

1. An individual eligible for escort and shopping services is disabled, frail, age sixty and over, who, because of limited mobility or other impairment, can no longer perform independently outside the home environment and requires one-on-one assistance to access outside services. Determination of need is made and documented by completion of the service recipient assessment in the form and manner prescribed by the department.

2. Transportation provided as part of this service must be provided in insured vehicles, driven by appropriately licensed drivers.

3. Escort and shopping assistance services providers are prohibited from performing the following service activities:

   a. Provision of services to individuals whose residential arrangements already include these services;

   b. Assistance given by a busdriver to help a passenger board or disembark from a bus and the accompaniment of a passenger to and from the bus is not considered a part of the transportation service.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-11. Comprehensive health maintenance program standard. Comprehensive health maintenance program is a combination of services provided in an effort to determine and maintain the health and well-being of service recipients. Services include monitoring and screening procedures for early detection of disease processes, health education, referral, and followup.

1. An individual eligible for comprehensive health maintenance program services is age sixty years and older, with preference

given to low income, low-income minority, isolated, physically or mentally handicapped, or frail.

2. Services may be provided at a senior center or other community facility with the following characteristics:

   a. There must be a private area which may be used to conduct health services.

   b. If the service recipient is homebound, services may be provided in the service recipient's home.

3. Service provider responsibilities include:

   a. Obtaining and recording the service recipient's name, date of birth, height, weight, family physician, medication being taken, health history, and name and telephone number of an emergency contact individual during initial intake.

   b. Recordkeeping for each service recipient. Records must include, at a minimum, the following information, if appropriate: date of service; followup provided; education and information provided; and other contact with a service recipient and the service recipient's physician.

   c. Providing information and education to each service recipient in conjunction with the health service provided.

   d. Providing monitoring or screening service procedures designed to address the following aspects of recipient's health: blood pressure measurement, blood sugar measurement, breast and pap smear exam, cholesterol measurement, ear irrigation, electrocardiogram monitoring, foot care, glaucoma screening, group education, hearing screening, hemocult and hemoglobin measurement, home visit, immunization, individual education, injections, medication setup, potassium measurement, prostate cancer screening, pulse monitoring, rapid inspection, urinalysis, and vision screening. The department must approve the offering or provision of any other procedures.

   e. Holding twelve screening clinics per year, offering seven different health maintenance services.

4. Service provider staffing requirements:

   a. The individual performing the health service must be licensed and certified by the applicable professional licensure board.

   b. A licensed medical physician (service recipient's physician or consultant physician) shall supervise and

oversee those activities which require medical procedures or physician involvement.

5. Comprehensive health maintenance program service providers are prohibited from performing the following service activities:

   a. The provision of medical diagnosis or treatment without holding current licensure and certification.

   b. The provision of nursing services, unless supervised by a registered nurse or licensed practical nurse, as regulated by the Nurse Practice Act.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-12. Nutrition program standard. Nutrition program is a service that provides meals to individuals in a congregate or home setting that meets the specific requirements. The service provides a nutritionally sound meal that promotes, maintains, and improves the health of service recipients, reduces isolation, and provides a link to other social and supportive services.

1. An eligible individual is age sixty years and older and the individual's spouse, regardless of age. Other eligible service recipients are:

   a. Volunteers under age sixty. Service providers may make available a meal if approved by service provider board action. The service provider must include specific criteria in the service provider's program policy and procedures' manual.

   b. Handicapped or disabled individuals under age sixty. Service providers may make available meals to individuals with handicaps or disabilities under age sixty that reside in a housing facility primarily occupied by older individuals at which there is a title III meal service location if approved by the service provider board action. The service provider must outline specific meal service locations in the service provider's program policy and procedures' manual.

   c. Disabled individuals residing with eligible service recipients. Service providers may make available meals to an individual with a disability who resides in a noninstitutional household if approved by the service provider board action. The service provider must include specific criteria in the service provider's program policy and procedures' manual.

2. Services may be provided in either congregate or home settings.

   a. Congregate meals are offered at a senior center or designated setting of service delivery located as close as feasible to the majority of eligible individuals' residences and which has planned access to a telephone.

   b. Home-delivered meals are offered in the homes of eligible service recipients. Determination of need is made and documented by completion of the service recipient assessment in the form and manner prescribed by the department. A service provider must conduct initial and subsequent assessments at least every six months, or sooner, as necessary.

3. Nutrition service providers are prohibited from performing the following service activities:

   a. Providing meals to an ineligible individual;

   b. Use of unapproved substitutions which alter the title III meal pattern;

   c. Use of home canned, prepared, or preserved foods; and

   d. Providing modified diets without the services of a registered dietitian or individual with comparable expertise.

4. Nutrition service providers must be certified for the use of food stamps.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-13. Outreach services. Outreach service is seeking out the older individual, identifying the individual's service needs, and providing information and assistance in linking the individual with services addressing the identified need.

1. An individual eligible for outreach services is age sixty years and older. Determination of need is made and documented by completion of the service recipient assessment in the form and manner prescribed by the department.

2. Each service recipient must have a case record.

3. Outreach general service activities include:

a. Addressing and responding to a referral by letter, telephone, or in person, for example, a face-to-face meeting, within two working days;

b. Identifying and contacting the service recipient and providing the service recipient with information on community services and resources;

c. Making home visits, assessing needs by observation and communication, and arranging for assistance, if needed and agreed to by the individual;

d. Performing administrative activities, including reporting, service provider linkages, and attending appropriate training; and

e. Following up on each referral to determine if service outcomes were met.

4. Outreach workers are prohibited from presenting to the public, by title or description of service, that any outreach worker is engaging in social work practice, unless currently licensed by the North Dakota board of social work examiners.

5. Outreach staff shall:

a. Complete a department-approved outreach training program within one year of employment.

b. Complete a minimum of ten hours per year of inservice training relative to outreach functions.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-14. Transportation program standard. Transportation services provide a method of travel from one specific location to another specific location to provide access to available medical, social, educational, rehabilitative, and personal services for the target population.

1. An individual eligible for transportation services is age sixty years or older.

2. Services are provided using licensed motor vehicles in the following categories which meet minimum federal, state, and local safety requirements:

a. Handicapped accessible and nonhandicapped accessible public mass transit bus;

b. Handicapped accessible and nonhandicapped accessible commercial intercity bus;

c. Handicapped accessible and nonhandicapped accessible noncommercial bus;

d. Taxi; and

e. Automobile.

3. Minimum staffing requirements include:

a. Possessing a valid drivers license appropriate to the motor vehicle used in service delivery;

b. Having had no vehicle moving violations within the last three years prior to employment;

c. Being able to complete a vehicle pretrip inspection as prescribed by the department of transportation; and

d. Acquiring first aid and cardiopulmonary resuscitation certification.

4. Transportation service providers are prohibited from performing the following activities:

a. Services restricted to an ambulance; and

b. Smoking in the vehicle.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

75-03-26-15. Senior center construction, acquisition, and renovation.

1. Applications must be submitted in the form and manner prescribed by the department.

2. Compliance with North Dakota Century Code section 48-02-19 is required for all buildings constructed or renovated with Older Americans Act funds.

3. Compliance with the state fire code is required for all buildings constructed or renovated with Older Americans Act funds.

History: Effective May 1, 1996.
General Authority: NDCC 50-06-01.4; 42 U.S.C. 3011, et seq.
Law Implemented: NDCC 50-06-16

JUNE 1996

CHAPTER 75-03-18

AGENCY SYNOPSIS: Amendments to North Dakota Administrative Code chapter 75-03-18, Procedures for Review of Child Abuse and Neglect Investigations, North Dakota Administrative Code chapter 75-03-19, Investigation of Child Abuse and Neglect Reports, and North Dakota Administrative Code chapter 75-05-06, Human Service Center Essential Client Services and Eligibility.

A public hearing was conducted on February 5, 1996, in Bismarck, concerning proposed amendments to North Dakota Administrative Code chapter 75-03-18, Procedures for Review of Child Abuse and Neglect Investigations, proposed amendments to North Dakota Administrative Code chapter 75-03-19, Investigation of Child Abuse and Neglect Reports, and proposed amendments to North Dakota Administrative Code chapter 75-05-06, Human Service Center Essential Client Services and Eligibility. The proposed amendments are necessary to conform these chapters to statutory changes to North Dakota Century Code chapter 50-25.1 as requested by the 1995 legislative assembly.

The proposed amendments require emergency rulemaking and were effective January 1, 1996. The proposed amendments are expected to have an impact on the regulated community in excess of $50,000. No taking of real property is involved in the rulemaking action.

Written comments were received from three commentors within the comment period. Two comments were received at the public hearing.

75-03-18-01. Definitions.

1. <u>"Assessing agency" means the county social service board in the county where the report of suspected abuse or neglect is</u>

assessed, or, in certain instances, a regional human service center. "Assessment" is defined in section 75-03-19-01.

2. "Decision" means the conclusion that determines whether services are required to provide for the protection and treatment of an abused or neglected child.

3. "Department" means the North Dakota department of human services or its designee.

~~2.~~ 4. "Determination" means the decision made by the state child protection team that ~~probable-cause-does-or-does-not-exist--to believe--that~~ institutional child abuse or neglect is or is not indicated.

~~3.--"Director"--means--the--executive-director-of-the-North-Dakota department-of-human--services,--or--the--executive--director's designee.~~

~~4.--"Investigating--agency"--means-the-county-social-service-board in-the-county-where-the-report-of-suspected-abuse--or--neglect was--investigated,--or,-in-certain-instances,-a-regional-human service-center.~~

5. "Regional human service center" means a facility established according to the provisions of North Dakota Century Code section 50-06-05.3.

6. "Subject" means any a person ~~investigated-who-is-suspected-as having-been-abused-or--neglected--during--childhood,--and--any person--investigated~~ named in a child abuse or neglect report who is suspected as having abused or neglected any child. "Subject" includes:

a. A child's parent;

b. A child's guardian;

c. A child's foster parent;

d. An employee of a public or private school or nonresidential child care facility;

e. An employee of a public or private residential home, institution, or agency; or

f. A person responsible for the child's welfare in a residential setting.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-04.1, 50-25.1-05.4

75-03-18-02. Who may file request for review.

1. The ~~subjects~~ subject of a report of suspected child abuse or neglect who are is aggrieved by the conduct or result of the ~~investigation--of--a-probable-cause-finding-of-suspected-child abuse-or-neglect~~ assessment if the decision is made that services are required to provide for the protection and treatment of an abused or neglected child may file an appeal ~~and-request-a-review-of-the-investigation:~~.

   ~~a.--A--child's-parent,-guardian,-foster-parent,-an-employee-of a-public-or-private-school-or--nonresidential--child--care facility,--an--employee-of-a-public-or-private-residential home,-institution-or-agency,-or-other--person--responsible for--the--child's--health--and--welfare--in--a-residential setting-who-is-a-subject-of-a-report--of--suspected--child abuse-or-neglect-as-the-alleged-perpetrator;-or~~

   ~~b.--A-child-who-is-a-subject-as-a-suspected-victim-of-a-report of-suspected-abuse-or--neglect--may--file--a--request--for review--directly--or-such-a-request-for-review-may-be-made on-behalf-of-such-a-child-by-a-parent--or--legal--guardian acting--on--behalf--of-and-in-the-best-interests-of-such-a child.~~

2. A staff member of child ~~protective~~ protection services will notify the ~~alleged--perpetrator~~ subject in writing of the ~~findings---of---the---probable--cause--investigation~~ decision resulting from an assessment. ~~At--the--time--of--the--initial interview,--the--staff--member--will--provide--to--the-alleged perpetrator-written-appeal-procedures-for-the-conduct--of--the investigation,-the-outcome-of-the-investigation,-or-both.~~ The staff member of child protection services who notifies the subject of the decision resulting from the assessment shall complete an affidavit of mailing that becomes a part of the assessment record in the form and manner prescribed by the department.

3. Written appeal procedures are available from the department upon request.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-05.4

75-03-18-03. Request for appeal to be in writing - Where filed - Content. A request for an appeal ~~of-an-investigation~~ must be in writing on forms developed and provided by the department. The ~~complaining~~ subject ~~must~~ shall submit the written request for an appeal and formal hearing to:

Appeals Supervisor
North Dakota Department of Human Services
State Capitol - Judicial Wing
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0250

The written request must include:

1. A succinct statement by the subject who meets the criteria in section 75-03-18-02 as to why the subject disagrees with the conduct of the ~~investigation--or--a--probable-cause-finding~~ assessment or the decision that services are required;

2. All reasons or grounds the subject disagrees with must be included in a single request for appeal~~;--either--as--to--the conduct-of-the-investigation,-the-result-of-the-investigation, or-both~~; and

3. A statement of the relief sought by the subject.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-05.4

75-03-18-04. Time for filing request for appeal - Standard for review.

1. An appeal may not be filed before the date of a-case ~~determination~~ an assessment decision and must be filed within thirty days after the documented date of the subject notification of the ~~determination~~ decision in accordance with procedures in chapter 75-01-03. A child protection services decision of "services required" is the only decision that may be appealed. Notification is considered to have occurred three days after the date on the affidavit of mailing.

2. ~~Probable--cause--findings-issued-before-July-31,-1993,-are-not subject-to-appeal.~~ The decision of the ~~investigating--agency~~ department must be affirmed unless the ~~investigating-agency~~ department acted arbitrarily, capriciously, or unreasonably in making its decision.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-05.4

75-03-18-05. Informal meeting. ~~Nothing--in--this~~ This chapter shall be construed to ~~forbid-any~~ encourage informal, mutually consensual meetings or discussions between the subject and the ~~department~~,

~~director,-investigating~~ assessing agency, or regional human service center. Such informal review will not suspend or extend the time for filing an appeal pursuant to section 75-03-18-04.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-05.4

75-03-18-07. Formal hearing.

1. The formal hearing, which is not a contested case hearing, must be conducted in substantial conformity with applicable provisions of chapter 75-01-03.

2. ~~The--hearing-must-be-conducted-according-to-any-fair-treatment standards-adopted-by-the-legislative-assembly-or--the--supreme court--for--the--protection--of-witnesses-or-children-in-court proceedings.~~ The appellant is the moving party and bears the burden of proof.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-05.4

75-03-18-07.1. Treatment of witnesses.

1. The hearing must be conducted according to any fair treatment standards adopted by the legislative assembly or the supreme court for the protection of witnesses or children in court proceedings.

2. If any child is to be called as a witness during the appeal hearing, whether for deposition, discovery, or for the hearing, the office of administrative hearings shall appoint a guardian ad litem for the child witness. The party calling the child as the witness is responsible for compensating the guardian ad litem.

History: Effective January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-03, 50-25.1-05.4

75-03-18-11. Evidence.

1. Any privilege of communication between husband and wife or between any professional person and that person's patient or client, except between attorney and client or involving members of the clergy acting as spiritual advisers, does not

constitute grounds for the exclusion of evidence during an ~~investigation~~ assessment of reported suspected child abuse or neglect, or during an appeal under this chapter or under North Dakota Century Code chapter 28-32.

2. Any statement, relied upon by the ~~director-or-the-director's designee,~~ department made by a child who is ~~a--subject--as~~ a suspected victim of a report of suspected child abuse or neglect or who is a witness to the suspected abuse or neglect of another child may be introduced into evidence.

3. Copies of any statements or any records sought to be entered into evidence shall be redacted to protect any statutory confidentiality requirements.

4. Copies of the assessment report as developed by child protection services must be considered admissible as nonhearsay evidence under rule 803(8) of the North Dakota Rules of Evidence.

History: Effective November 1, 1994; amended effective January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-03, 50-25.1-05.4

75-03-18-12. Effect of appeal. Neither a request for appeal under this chapter nor an appeal from that decision under North Dakota Century Code chapter 28-32 shall be construed to suspend the legal effect of ~~a-case-determination~~ an assessment decision during the time of the appeal until such time as a final decision overturning the case ~~determination~~ decision has been made and not appealed.

History: Effective November 1, 1994; amended effective January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-05.4

75-03-18-13. Effect of overturn of case ~~determination~~ decision or appeal. If ~~a-case-determination~~ an assessment decision is reversed on appeal under this chapter or under North Dakota Century Code chapter 28-32, a notation of the fact that the finding was overturned must be added to the record.

History: Effective November 1, 1994; amended effective January 1, 1996.
General Authority: NDCC 50-25.1-05.4
Law Implemented: NDCC 50-25.1-05.4

CHAPTER 75-03-19

75-03-19-01. Definitions. The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 50-25.1, except:

1. "Assessment" is the factfinding process designed to provide information which enables a decision to be made to provide for the protection and treatment of an abused or neglected child. An assessment is a proceeding under North Dakota Century Code section 50-25.1-10.

2. "Determination Decision" means the ~~decision--that-probable cause-does-or-does-not-exist-to-believe-that--child--abuse--or neglect---is--indicated~~ conclusion that determines whether services are required to provide for the protection and treatment of an abused or neglected child.

~~2.--"Investigation"-is-the-factfinding-process-designed-to-provide information-which-enables-a--determination--to--be--made--that probable--cause--does-or-does-not-exist-to-believe-child-abuse or-neglect-is-indicated.--An--investigation--is--a--proceeding under-North-Dakota-Century-Code-section-50-25.1-10.~~

3. "Department" means the North Dakota department of human services.

4. "Subject" means a person named in a child abuse or neglect report who is suspected as having abused or neglected any child. "Subject" includes:

   a. A child's parent;

   b. A child's guardian;

   c. A child's foster parent;

   d. An employee of a public or private school or nonresidential child care facility;

   e. An employee of a public or private residential home, institution, or agency; or

   f. A person responsible for the child's welfare in a residential setting.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05
Law Implemented: NDCC 50-25.1-05

75-03-19-02. County social service boards to receive reports and conduct ~~investigations~~ assessments - Reimbursement. County social service boards shall act as designee of the department for the purpose of receiving reports of suspected child abuse or neglect and conducting ~~investigations~~ assessments, except as otherwise provided for by law or as otherwise determined by the department in a particular case. The department shall reimburse such designees, in a reasonable amount determined by the department, to the extent ~~of~~ funds are made available to the department for ~~such~~ these purposes. No person or agency may be required to act as the department's designee if the department is unable to provide ~~such~~ reimbursement for services rendered.

History: Effective September 1, 1990; amended effective January 1, 1996.
General Authority: NDCC 50-25.1-05
Law Implemented: NDCC 50-25.1-02(3), 50-25.1-04, 50-25.1-05, 50-25.1-05.1

75-03-19-03. Time for initiating ~~investigations~~ assessments - Emergencies. All nonemergency child abuse or neglect ~~investigations~~ assessments must be initiated no later than seventy-two hours after receipt of a report by the ~~investigating~~ assessing agency unless the department ~~shall--prescribe~~ prescribes a different time in a particular case. In ~~emergency~~ cases involving a serious threat or danger to the life or health of a child, the ~~investigation~~ assessment and any appropriate protective measures must commence immediately upon receipt of a report by the ~~investigating~~ assessing agency. An ~~investigation~~ assessment is initiated by ~~an--interview~~ a search of records for information relating to the report, contact with a subject of the report, or with a collateral contact.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05
Law Implemented: NDCC 50-25.1-05

75-03-19-04. Time for completing ~~investigations~~ assessments. ~~Investigations~~ Assessments of reports of suspected child abuse or neglect must be completed and a ~~determination~~ decision made within thirty-one days from the date of receipt of the report unless an extension of the time is requested of and granted by the department.

History: Effective September 1, 1990; amended effective January 1, 1996.
General Authority: NDCC 50-25.1-05
Law Implemented: NDCC 50-25.1-05

75-03-19-05. Time for submitting written ~~investigative~~ assessment reports. The written ~~investigative~~ assessment report must be completed and submitted to the regional child ~~protective~~ protection service

supervisor or other person designated by the department to receive the ~~investigative~~ assessment report within thirty-one days of the date of the ~~determination~~ decision, unless an extension of time is requested of and granted by the department.

History: Effective September 1, 1990; amended effective January 1, 1996.
General Authority: NDCC 50-25.1-05
Law Implemented: NDCC 50-25.1-05

75-03-19-06. ~~Investigation~~ Assessment procedures. ~~Investigations~~ Assessments of reports of suspected child abuse or neglect must be conducted by the department or by its designee in substantial conformity with the policies of the department. ~~Investigations~~ Assessments of reports of suspected child abuse or neglect must reflect:

1. An assessment process designed to collect sufficient information to ~~determine if probable cause does or does not exist to believe child abuse or neglect is indicated and to assess the risk of future harm to children~~ make a decision whether services are required to provide for the protection and treatment of an abused or neglected child;

2. Assessment techniques that include interviewing and observing ~~subjects~~ the subject, the child victim, and other interested or affected persons and documenting those interviews and observations;

3. Conclusions and a summary based on information gathered by assessment techniques described in subsection 2; and

4. ~~Development~~ If services are required, development of a treatment ~~and prevention~~ plan based on goals and objectives established by the department or its designee and the ~~family of the~~ subject and the family of the child victim.

History: Effective September 1, 1990; amended effective November 1, 1994; January 1, 1996.
General Authority: NDCC 50-25.1-05, 50-25.1-05.4
Law Implemented: NDCC 50-25.1-05, 50-25.1-05.4

75-03-19-07. Caseload standards. Any agency designated by the department to receive reports and conduct assessments of reports of suspected child abuse or neglect shall adhere to the caseload standards establishing minimum staff to client ratios~~, as such standards are developed and disseminated by the department~~.

History: Effective September 1, 1990; amended effective January 1, 1996.
General Authority: NDCC 50-25.1-05
Law Implemented: NDCC 50-25.1-05, 50-25.1-06.1

75-03-19-08. Exchange and transfer of information. The department and any agency designated by the department to receive reports and conduct ~~investigations~~ assessments of suspected child abuse or neglect may exchange or transfer information and records concerning ~~such~~ the reports or ~~investigations~~ assessments among and between personnel of each respective agency to the extent necessary to perform the duties and effectuate the purposes set forth in North Dakota Century Code chapter 50-25.1.

History: Effective September 1, 1990; amended effective January 1, 1996.
General Authority: NDCC 50-25.1-05
Law Implemented: NDCC 50-25.1-05, 50-25.1-11

75-05-06-04. Vulnerable children and adolescents. This population group is characterized by a need to protect children from emotional and physical violence in the home, prevent further victimization, and diagnose and treat emotional disturbance, substance abuse, and other disabling conditions. The overall goal of the appropriate services provided is to increase the child's potential for a productive life and to preserve family unity.

1. Appropriate services for abused or neglected children are available to:

   a. Children who are current ~~subjects--of~~ victims in an ~~investigation~~ assessment of alleged abuse or neglect;

   b. Children who are determined to be at risk of abuse or neglect, based on an ~~investigation~~ assessment that concludes that services are recommended, or are ~~subjects of-a-probable-cause--determination~~ victims based on an assessment that concludes that services are required;

   c. Children who are affected by the abuse or neglect of their siblings; or

   d. Children who have been abused by a noncaretaker.

2. Appropriate services are available to noncaretaker perpetrators of child sexual abuse.

3. Appropriate services are available to children and adolescents involved in domestic violence who:

   a. Are affected by physical or emotional violence in the home; or

   b. Are perpetrators of physical or emotional violence in the home.

4. Appropriate services are available to emotionally disturbed children and adolescents who:

   a. For purposes of evaluation only, appear to be emotionally disturbed;

   b. For continuing services, are emotionally disturbed, and whose behavior exhibits one or more of the following:

      (1) Gross impairment in communication;

      (2) Some danger of hurting self or others;

(3) Occasional failure to maintain minimal personal hygiene;

(4) Behavior considerably influenced by delusions or hallucinations;

(5) Serious impairment in communication or judgment;

(6) Inability to function in almost all areas;

(7) Some impairment in reality testing or communication;

(8) Major impairment in several areas, such as work, school, family relations, judgment thinking, or mood;

(9) Serious symptoms such as suicidal ideation or severe obsessional rituals;

(10) Serious impairment in social, occupational, or school functioning;

(11) Moderate symptoms, such as flat affect and circumstantial speech or occasional panic attacks;

(12) Moderate difficulty in social, occupational, or school functioning;

(13) Some mild symptoms, such as depressed mood or mild insomnia;

(14) Some difficulty in social, occupational, or school functioning, but generally functioning well and has some meaningful interpersonal relationships;

(15) Attention deficit disorder; or

(16) Disruptive behavior disorder; or

c. Are involved in therapy as a part of the treatment plan for a family member.

5. Appropriate services are available to children and adolescents with a diagnosis of mental retardation made by a licensed or license exempt psychologist based on an individually administered standardized intelligence test and standardized measure of adaptive behavior, and who are:

a. Children from birth through age two, for purposes of infant development services;

b. School age children in need of transition services from school to adult programs; or

c. Any child or adolescent who is determined in need of family support services or in need of intermediate care facility for mentally retarded placement.

6. Appropriate services are available to children and adolescents who have a condition other than mental illness, so severe as to constitute a developmental disability, which results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and who are:

   a. Children from birth through age two, for purposes of infant development services;

   b. School age children in need of transition services from school to adult programs; or

   c. Any child or adolescent who is determined in need of family support services or in need of intermediate care facility for mentally retarded placement.

7. Appropriate services are available to children and adolescents with physical and nondevelopmental disabilities who:

   a. Have a mental or physical disability that prevents them from obtaining, retaining, or preparing for employment; or

   b. Are children from birth through age two, exhibiting developmental delays, but who are not determined to have developmental disabilities.

8. Appropriate services are available to children and adolescents involved in substance abuse who are:

   a. Charged with or adjudicated for an alcohol-related or drug-related offense;

   b. Known or suspected of abuse of alcohol or other drugs; or

   c. Affected by the alcohol or drug addiction of others.

History: Effective February 1, 1995; amended effective January 1, 1996.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03

TITLE 81

Tax Commissioner

APRIL 1996

CHAPTER 81-03-04

81-03-04-01. Corporation required to report and pay estimated tax~~,-penalty~~ and interest - Refund of overpayment.

1. Any corporation may elect to make a payment of estimated income tax with the tax commissioner.

2. A corporation is required to make a payment of estimated tax with the tax commissioner if:

   a. The corporation's previous year's state income tax liability exceeded five thousand dollars; and

   b. The corporation reasonably expects the current state income tax liability to be in excess of five thousand dollars.

3. For the purpose of this section, tax liability is defined as the amount of North Dakota tax due computed after the application of allowable credits and before the application of estimated payments.

4. When making payment of estimated income tax, a corporation has the option of basing the estimation on the tax liability for the previous year or on an estimate of the liability for the current tax year.

5. The payment of estimated income tax must be made on or before the fifteenth day of the fourth month of the current corporate tax year. The original payment of estimated income tax may be

amended any time before the fifteenth day of the first month of the tax year following the current tax year.

6. A corporation shall pay the estimated tax liability in four equal installments payable on the fifteenth day of the fourth, sixth, and ninth month of the current tax year and the fifteenth day of the first month of the following tax year. As an alternative to paying in quarterly installments, a corporation may pay the entire estimated amount on the fifteenth day of the fourth month of the current tax year.

7. For taxable years beginning after December 31, 1986, the provisions for recurring seasonal income as provided in section 6655(e) of the Internal Revenue Code are recognized for state income tax purposes.

8. For taxable years beginning after December 31, 1990, the provisions for the annualized or adjusted seasonal method of determining estimated income under section 6655 of the Internal Revenue Code are recognized for state income tax purposes.

9. ~~Penalty--and--interest~~ For purposes of subsection 5 of North Dakota Century Code section 57-38-62:

   a. An amended return filed on or before the due date, including extensions for filing the original return, is the corporation's return for that taxable year.

   b. An audit assessment does not affect the calculation of estimated tax payments.

10. Interest shall apply in the following conditions:

   a. A corporation did not pay the estimated tax on or before the quarterly due date.

   b. The quarterly estimated payments were underpaid by more than ten percent of the actual tax liability for the current tax year divided by four. However, no ~~penalty or~~ interest will apply if the quarterly estimated payments equaled the previous year's total tax divided by four.

~~10.~~ 11. Interest is computed from the due date of the quarterly installment to the date of actual payment. Estimated tax payments, received as a result of an amendment to the originally estimated tax, will have interest computed from the date paid to the date due in the related quarters.

~~11.~~ 12. If the total amount of estimated tax payments exceed the total amount of tax required to be paid for the current tax year, the overpayment will be refunded.

~~12.~~ 13. a. If the total amount of estimated tax payments exceeds the anticipated tax liability for the tax year by more than five hundred dollars, a quick refund may be requested. The request for refund must be filed on forms provided by the tax commissioner. In addition, the request must be filed after the close of the tax year and before the original due date of the tax return. No interest will be paid on a quick refund.

b. If a quick refund of estimated income tax results in a corporation's failure to meet the requirements of North Dakota Century Code section 57-38-62, ~~penalty and~~ interest provisions will apply.

History: Effective July 1, 1985; amended effective November 1, 1987; November 1, 1991; August 1, 1994; April 1, 1996.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-62

81-03-04-02. Payments of estimated taxes by individuals, estates, and trusts.

1. Except as otherwise provided, an individual, estate, or trust subject to section 6654 of the Internal Revenue Code, relating to failure to pay estimated income taxes, shall make payments of estimated state income tax.

2. ~~Penalty--and--interest~~ For purposes of subsection 5 of North Dakota Century Code section 57-38-62:

   a. An amended return filed on or before the due date, including extensions for filing the original return, is the individual's, estate's, or trust's return for that taxable year.

   b. An audit assessment does not affect the calculation of estimated tax payments.

3. Interest for failure to make payments of estimated state income tax must be waived by the tax commissioner in the following situations:

   a. When an individual derives over two-thirds of gross income from farming, files a federal income tax return by March first of the following tax year, and pays the federal tax in full by that same date, but does not make payments of estimated state income tax. The individual does not have to file a state income tax return or pay any state income tax due on or before March first of the following tax year to qualify for this waiver of ~~penalty and~~ interest.

b. When an individual derives over two-thirds of gross income from farming, makes the one required estimated federal tax installment on January fifteenth of the following tax year, files a federal income tax return after March first of the following tax year, and pays the estimated state income tax due on January fifteenth of the following tax year. The first three payments due on April fifteenth, June fifteenth, and September fifteenth of the current tax year are not required to qualify for this waiver of ~~penalty and~~ interest.

c. When an individual, estate, or trust utilizes the annualized income installment method for federal purposes as provided in section 6654 of the Internal Revenue Code, and makes the required estimated state income tax payment based thereon.

d. When an individual, estate, or trust has a current year tax liability which exceeds the taxpayer's withholding by less than two hundred dollars, and the taxpayer does not make payments of estimated state income tax. The two hundred dollar limitation applies per return.

~~3.~~ 4. To determine tax liability for the immediately preceding year, married taxpayers who filed separate returns in the prior year, but who plan to file a joint return for the current year, shall combine the tax liabilities reflected on their prior year returns. Joint estimated tax payments for the current year must equal or exceed one hundred percent of the couple's total tax liability for the prior year if the prior year test is applicable.

History: Effective November 1, 1987; amended effective July 1, 1989; March 1, 1990; November 1, 1991; April 1, 1996.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-45, 57-38-62, 57-38-63, 57-38-64

81-09-02-17. Definition of gas base rate adjustment and tax rate. The gas base rate adjustment and the tax rate on taxable gas production reported in MCF for fiscal years beginning July 1, 1992, and subsequent years, are as follows:

FISCAL YEAR	BASE RATE ADJUSTMENT	TAX RATE PER MCF
July 1, 1992, through June 30, 1993	1.018494	$ .0407
July 1, 1993, through June 30, 1994	1.002642	$ .0401
July 1, 1994, through June 30, 1995	1.036988	$ .0415
July 1, 1995, through June 30, 1996	0.961691	$ .0385

History: Effective August 1, 1994; amended effective April 1, 1995; April 1, 1996.
General Authority: NDCC 57-51-21
Law Implemented: NDCC 57-51-02.2

81-09-03-02. Definitions. As used in these sections and for the administration of North Dakota Century Code chapter 57-51.1, unless the context requires otherwise, the following definitions apply:

1. "Completion" or "completed" means an oil well will be considered completed when the first oil is produced through wellhead equipment after production casing has been run.

2. "Drilled" means the spudding of a well.

3. "Horizontal reentry well" means a well that was initially drilled and completed as a vertical well which is reentered and recompleted as a horizontal well after March 31, 1995. A horizontal reentry well includes a vertical well classified by the industrial commission as a dry hole which is reentered and recompleted as a horizontal well after March 31, 1995. As applied to the horizontal reentry of a vertical well, a reentry means the reentering of a well that has been plugged as determined by the industrial commission under section 43-02-09-01.

4. "Incremental production" means the oil which has been classified as incremental by the industrial commission pursuant to subsections 5 and 6 of North Dakota Century Code section 57-51.1-03.

~~4.~~ 5. "New well" means a well initially drilled and originally completed after April 27, 1987, to a separate and distinct reservoir as recognized by the industrial commission.

~~5.~~ 6. "Nonincremental production" means the oil which has not been classified as incremental by the industrial commission.

~~6.~~ 7. "Reservoir" means a common source of supply as defined by the industrial commission.

~~7.~~ 8. "Test oil" means oil recovered during and after drilling but before normal completion of a well.

~~8.~~ 9. "Unit" means the total area of land that results from the combining of interests in all or parts of two or more leases or fee interests in order to operate the reservoir as a single production unit subject to a single operating interest. A unit may be formed by an agreement between the mineral interest owners (voluntary unitization) or by order of an agency of the state or federal government (compulsory unitization). A unit does not include "poolings" resulting

from the enforcement of spacing requirements. This definition is only effective for periods prior to April 27, 1987.

History: Effective August 1, 1986; amended effective October 1, 1987; March 1, 1990; June 1, 1992; April 1, 1996.
General Authority: NDCC 57-51-21, 57-51.1-05
Law Implemented: NDCC 57-51.1-01(3)(4)(5)(8), 57-51.1-03(3)

81-09-03-06. New well exemption for vertical and horizontal wells.

1. Oil produced from a vertical new well during the first fifteen consecutive months starting with the date the well was completed is exempt from the oil extraction tax. ~~This~~

2. For a horizontal new well drilled and completed after April 27, 1987, but before April 1, 1995, oil produced from the horizontal new well during the first fifteen consecutive months starting with the date the well was completed is exempt from the oil extraction tax.

3. For a horizontal new well drilled and completed after March 31, 1995, oil produced from the horizontal new well during the first twenty-four consecutive months starting with the date the well was completed is exempt from the oil extraction tax.

4. The fifteen-month ~~period--runs~~ and twenty-four-month exempt periods run consecutively from the date the well is completed even though all or a portion of the new well exemption may be rendered ineffective by the oil price trigger discussed below.

5. Test oil from a new well is also exempt from the oil extraction tax. Only one new well exemption is allowed per well bore. The well bore of a horizontal well consists of both the vertical and horizontal segments.

~~2.~~ 6. To be eligible for ~~this~~ the new well exemption, a producer must submit a new well qualification letter signed by a representative of the industrial commission. This qualification letter must state the date the well was spudded, the date the well was completed, and the total volume of test oil recovered prior to completion, and, if applicable, that the well was drilled and completed as a horizontal well after March 31, 1995. The tax commissioner will accept the information provided in the qualification letter subject to confirmation upon audit.

~~3.~~ 7. If the average price of a barrel of crude oil, as defined in subsection 2 of North Dakota Century Code section 57-51.1-01, is thirty-three dollars or more, for any consecutive five-calendar-month period, the new well exemption is

ineffective. If, however, the average price of oil then declines below thirty-three dollars per barrel for any subsequent consecutive five-calendar-month period, the new well exemption is reinstated beginning on the first day of the first month following the five-month period in which the average price of crude oil was below thirty-three dollars per barrel.

History: Effective October 1, 1987; amended effective March 1, 1990; June 1, 1992; April 1, 1996.
General Authority: NDCC 57-51-21, 57-51.1-05
Law Implemented: NDCC 57-51.1-03(3)

81-09-03-10. Horizontal reentry well exemption.

1. Oil produced from a horizontal reentry well during the first nine consecutive months starting with the date the well was recompleted as a horizontal well is exempt from the oil extraction tax.

   The designation of a horizontal reentry well is given to a well initially drilled and completed as a vertical well which is reentered and recompleted as a horizontal well after March 31, 1995. This designation may also apply to the reentry and recompletion of a vertical well that is classified by the industrial commission as a dry hole.

2. The nine-month exempt period runs consecutively from the date the horizontal reentry well is recompleted even though all or a portion of the exemption may be rendered ineffective by the oil price trigger described in this section.

3. Test oil from a horizontal reentry well is exempt from the oil extraction tax. The well bore of a horizontal reentry well consists of both the vertical and horizontal segments.

4. After the nine-month exempt period expires, oil produced from a horizontal reentry well is subject to the same oil extraction tax rate that was applicable before the exempt period.

5. To be eligible for the horizontal reentry well exemption, a producer must submit a qualification letter signed by a representative of the industrial commission. This qualification letter must state the dates the well was initially spudded and completed as a vertical well, the dates the well was reentered and recompleted as a horizontal well, the total volume of test oil recovered prior to recompletion, and, if applicable, the date the well was initially plugged and abandoned as a dry hole.

6. If the average price of a barrel of crude oil, as defined in North Dakota Century Code section 57-51.1-01, is thirty-three dollars or more, for any consecutive five-calendar-month period, the horizontal reentry well exemption is ineffective. If, however, the average price of oil then declines below thirty-three dollars per barrel for any subsequent consecutive five-calendar-month period, the horizontal reentry exemption is reinstated beginning on the first day of the first month following the five-month period in which the average price of crude oil was below thirty-three dollars per barrel.

History: Effective April 1, 1996.
General Authority: NDCC 57-51-21, 57-51.1-05
Law Implemented: NDCC 57-51.1-03(7)

81-09-03-11. Two-year inactive well exemption.

1. Oil produced from a two-year inactive well is exempt from the oil extraction tax for a period of ten years starting with the first day of the month in which the industrial commission's certification of well status is received by the tax commissioner.

2. A two-year inactive well is a well that has not produced oil in more than one month in the twenty-four-month period immediately preceding the date an application for well status is received by the industrial commission. A well that has never produced oil, a dry hole, and a plugged and abandoned well are eligible for status as a two-year inactive well.

3. The inactive well exemption is applicable to all oil produced during the exemption period after the well is certified as a two-year inactive well.

4. The ten-year exempt period runs consecutively from the month the tax commissioner receives the industrial commission's certification even though all or a portion of the inactive well exemption may be rendered ineffective by the oil price trigger described in this section.

5. To be eligible for the inactive well exemption, a producer must submit a copy of the industrial commission's certification stating the date the application for well status was received by the industrial commission and stating that the well qualifies as a two-year inactive well.

6. If the average price of a barrel of crude oil, as defined in North Dakota Century Code section 57-51.1-01, is thirty-three dollars or more, for any consecutive five-calendar-month period, the inactive well exemption is ineffective. If, however, the average price of oil then declines below thirty-three dollars per barrel for any subsequent consecutive

five-calendar-month period, the inactive well exemption is reinstated beginning on the first day of the first month following the five-month period in which the average price of crude oil was below thirty-three dollars per barrel.

History: Effective April 1, 1996.
General Authority: NDCC 57-51-21, 57-51.1-05
Law Implemented: NDCC 57-51.1-03(6)

ARTICLE 81-11

MUNICIPAL WASTE SURCHARGE

[Repealed effective April 1, 1996]

TITLE 92

Workers' Compensation Bureau

92-01-02-45.1. Provider responsibilities and billings.

1. A provider may not submit a charge for a service which exceeds the amount which the provider charges for the same type of service in cases unrelated to workers' compensation injuries.

2. All bills must be fully itemized, including ICD-9-CM codes, and services identified by code numbers and descriptions found in the fee schedules or as otherwise provided for in these rules. The definitions of commonality in the guidelines found in the current procedural terminology must be used as guides governing the descriptions of services, except as otherwise provided in the fee schedules or in these rules.

3. All health care providers shall submit bills referring to one claim only for medical services on current form UB 82 or form HCFA 1500, except for dental billings which must be submitted on American dental association J512 dental claim forms. Bills and reports must include:

   a. The employee's full name and address;

   b. The employee's claim number and social security number;

   c. Date and nature of injury;

   d. Area of body treated, including ICD-9-CM code identifying right or left, as appropriate;

   e. Date of services;

f. Place of service;

g. Type of service;

h. Appropriate procedure code or hospital revenue code;

i. Description of service;

j. Charge for each service;

k. Units of service;

l. If dental, tooth numbers;

m. Total bill charge;

n. Name of practitioner providing service along with the provider's tax identification number;

o. Date of bills; and

p. Submission of supporting documentation or chart notes documenting services that have been billed.

4. Any correspondence received must be legible and reproducible. Legible copies of office or progress notes are required for all followup visits. Office notes are not acceptable in lieu of requested narrative reports. Communications should refer to one claim only.

5. Providers must supply a copy of an appropriate record that adequately documents the service and substantiates the nature and necessity of the service or charge. The following supporting documentation is required when billing for services:

a. Laboratory and pathology reports;

b. X-ray findings;

c. Operative reports;

d. Office notes, physical therapy, and occupational therapy progress notes;

e. Consultation reports;

f. History, physical examination, and discharge summaries;

g. Special diagnostic study reports; and

h. Special or other requested narrative reports.

6. When a provider of medical services, including a hospital, submits a bill to the bureau for medical services, the medical provider shall submit a copy of such a bill to the employee to whom the services were provided. The copy to the employee must be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the employee.

7. Pursuant to subsection 4 of North Dakota Century Code section 65-05-07, a provider may not collect or attempt to collect payment from an injured employee, the employer, or any other insurer or government for an excessive charge or a charge ~~deemed~~ determined to be not medically necessary. A The provider must remove the charge ~~must be removed by the provider~~ from subsequent bill statements if the bureau has determined the charge is excessive or not medically necessary. Disputes arising out of reduced or denied reimbursement are handled in accordance with section 92-01-02-46. In all cases of accepted compensable injury or illness under the jurisdiction of the workers' compensation law, a provider may not pursue payment for treatment rendered to the injured employee ~~is not liable for payment for any services for the treatment of that injury or illness, with the following exceptions~~ unless the treatment was provided under the following conditions:

   a. ~~When the~~ The injured employee seeks sought treatment from that provider for conditions not related to the ~~accepted~~ compensable injury or illness;.

   b. ~~When the~~ The injured employee seeks sought treatment from that provider which has not been prescribed by the employee's attending doctor. This would include ongoing treatment by the provider who is a nonattending ~~doctors;~~ doctor.

   c. ~~When the~~ The injured employee seeks sought palliative care from that provider, except as provided in section 92-01-02-40, after the employee ~~has been~~ was provided notice that the employee ~~is~~ was medically stationary; and palliative care is the service for which payment is requested.

   d. ~~When the~~ The injured employee seeks sought treatment from that provider after being notified that ~~such~~ the treatment sought from that provider has been determined to be unscientific, unproven, outmoded, or experimental; ~~and~~.

   e. ~~When the~~ The injured employee did not follow the requirements of subsection 1 of North Dakota Century Code section 65-05-28 regarding change of doctors before seeking treatment of the work injury from the provider requesting payment for that treatment.

f. The injured employee is subject to North Dakota Century Code section 65-05-28.2, and the provider requesting payment is not a preferred provider and has not been approved as an alternative provider under subsection 2, 3, or 4 of North Dakota Century Code section 65-05-28.2.

8. A health care provider may not bill for services not provided to the worker. A health care provider may not bill multiple charges for the same service. Rebilling must indicate that the charges have been previously billed.

9. Pursuant to North Dakota Century Code section 65-05-33, a health care provider may not submit false or fraudulent billings. As used in this section, "false or fraudulent" means an intentional deception or misrepresentation issued with the knowledge that the deception could result in unauthorized benefit to the provider or some other person.

10. Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

11. When an employee is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to the admission must be considered part of the inpatient treatment.

12. Physician assistant or nurse practitioner fees will be paid at the rate of eighty percent of a doctor's fee for a comparable service. The bills for these services must be marked with modifier NP.

13. A physical medicine modality or manipulation, when applied to two or more areas at one visit, must be reimbursed at one hundred percent of the maximum allowable fee for the first area treated, fifty percent for the second area treated, and twenty-five percent for all subsequent areas treated.

14. When ultrasound, diathermy, microwave, infrared, and hot packs are used in combinations of two or more during one treatment session, only one may be reimbursed, unless two separate effects are demonstrated.

15. When multiple areas are examined using CAT scan or magnetic resonance imaging, the first area examined must be reimbursed at one hundred percent, the second area at fifty percent, and the third and all subsequent areas at twenty-five percent of the allowable fee schedule amount.

16. When a health care provider is asked to review records or reports prepared by another health care provider, the provider should bill for its review of the records utilizing current procedural terminology code 99080 with a descriptor of "record

review". The billing should include the actual time spent reviewing the records or reports and should list the health care provider's normal hourly rate for such review. This would include records reviewed for independent medical examination reports.

17. When there is a dispute over the amount of a bill or the necessity of services rendered, the bureau shall pay the undisputed portion of the bill and provide specific reasons for nonpayment or reduction of each medical service code. Resolution of treatment disputes and fee disputes must be made in accordance with section 92-01-02-46.

18. Conditions preexisting or unrelated to the compensable injury are not the responsibility of the bureau. If medical documentation outlines that another condition is being treated concurrently with the compensable injury and the unrelated condition has no effect on the compensable injury, the bureau may reduce the charges submitted for treatment. When an unrelated condition is being treated concurrently with the occupational condition, the attending doctor must notify the bureau immediately and submit the following:

    a. Diagnosis or nature of unrelated condition.

    b. Treatment being rendered.

    c. The effect, if any, on the occupational condition.

    A thorough explanation of how the unrelated condition is affecting the compensable injury must be included with any request for authorization to treat the unrelated condition. Temporary treatment of an unrelated condition may be allowed, upon prior approval by the bureau, provided these conditions directly retard recovery of the compensable condition. The bureau will not approve or pay for treatment for a known preexisting unrelated condition for which the employee was receiving treatment prior to the occupational injury or disease, which is not retarding recovery of the occupational condition. The bureau may not pay for treatment of an unrelated condition when it no longer exerts any influence upon the compensable injury. When treatment of an unrelated condition is being rendered, reports must be submitted monthly outlining the effect of treatment on both the unrelated and the compensable injury conditions.

19. In cases of questionable liability where the bureau has not rendered a decision on compensability and where the provider has billed the injured employee or other insurance, and the claim is subsequently allowed, the provider shall refund the injured employee or other insurer in full and bill the bureau for services rendered.

20. The bureau does not pay for the cost of duplicating records when covering the treatment received by the injured employee. In cases where the bureau requests additional records to those listed in subsection 5 or records prior to the date of injury, the bureau will pay a minimum charge of five dollars for five or less pages and the minimum charge of five dollars plus thirty-five cents per page for every page after the first five pages.

21. The provider shall undertake professional judgment to assign the correct approved billing code for the service rendered using the appropriate provider group designation. Bills received without codes must be returned to the provider.

22. Billing codes must be found in the most recent edition of the following: physician's current procedural terminology; HCFA (health care financing administration) common procedure coding system (HCPCS); code on dental procedures and nomenclature maintained by the American dental association; or any other code listed in the fee schedules.

23. Pursuant to subsection 6 of North Dakota Century Code section 65-05-07, providers shall comply within thirty calendar days with the bureau's request for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the bureau's determination of compensability, medical necessity, or excessiveness or the bureau may assess a one hundred dollar penalty for failure to comply.

History: Effective January 1, 1994; amended effective April 1, 1996.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07, 65-05-28.2

92-01-02-52. Procedure for penalizing delinquent employer accounts.

1. The bureau shall bill annually each employer for premiums as provided by North Dakota Century Code chapter 65-04. If an employer's payroll report is received by the bureau on or before the fifteenth day of the month following the expiration of the employer's payroll period, the first billing statement will be mailed to the employer on or about the last day of the month following the expiration of the payroll period. If an employer's payroll report is received by the bureau after the fifteenth day but not later than the end of the month following the expiration of the employer's payroll period, the first billing statement will be mailed to the employer on or about the fifteenth day of the second month following the expiration of the payroll period. The first billing statement must identify the amount due from the employer and the payment

due date. The statement also must explain the quarterly payment option.

2. The payment due date for an employer's account for which a payroll report has been submitted on time is fifteen days after the bureau mails the first billing statement to the employer by regular mail addressed to the last known address of the employer. The payment due date for an employer's account for which a payroll report has not been submitted on time is the fifteenth day of the month following the expiration of the payroll period.

3. If full payment or a quarterly installment payment is not received by the bureau on or before the payment due date, the bureau shall send a second billing statement. This second statement must identify the amount due from the employer and the penalties to which the employer may be subjected under this section and North Dakota Century Code section 65-04-23.

4. On the fifteenth day after the payment due date, the bureau shall assess a penalty of one hundred dollars plus two percent of the amount of premium, penalties, and interest in default.

5. On the thirtieth day after the due date, the bureau shall assess a penalty of one hundred fifty dollars plus two percent of the amount of premium, penalties, and interest in default. At that time the bureau shall notify the employer, by regular mail addressed to the employer's last known address, that the account will be canceled and the employer will be uninsured unless payment is received by the bureau within fifteen days.

6. On the forty-fifth day after the payment due date, the bureau shall cancel the employer's account and shall notify the employer, by regular mail addressed to the employer's last known address, that the employer is uninsured.

7. The bureau may extend coverage by written binder if the bureau and the employer have agreed in writing to a payment schedule on a delinquent account, but an employer is not insured if the employer is in default of the agreed payment schedule.

History: Effective April 1, 1996.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-23

STAFF COMMENT: Chapter 92-01-03 contains all new material and is not underscored so as to improve readability.

CHAPTER 92-01-03
WORKERS' ADVISER PROGRAM

92-01-03-01. History and functions of the workers' adviser program.

1. History. Legislation enacting the workers' adviser program was passed in 1995 and is codified as North Dakota Century Code section 65-02-27. The legislation took effect on August 1, 1995.

2. Functions. The program has been developed to educate and provide assistance to injured employees in the workers' compensation system. The goal is to resolve claims disputes in a timely and professional manner. If an employee has a complaint concerning a claim, the employee may contact the workers' adviser program and request assistance.

History: Effective April 1, 1996.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

92-01-03-02. Definitions. In this chapter:

1. "Act" means the North Dakota Workers Compensation Act.

2. "Attempt to resolve" means a prompt, active, honest, good faith effort by the claimant to settle disputes with the program.

3. "Benefits" means an obligation of the bureau to provide a claimant with assistance as required by the Act.

4. "Bureau" means the North Dakota workers compensation bureau, or the director, or any department heads, assistants, or

employees of the bureau designated by the director to act within the course and scope of their employment in administering the policies, powers, and duties of the Act.

5. "Claimant" means an employee who has filed a claim for benefits with the bureau.

6. "Disputed claim" means a challenge to an order issued by the bureau.

7. "Field office" means a regional office of the workers' adviser program.

8. "Informal benefit review conference" means a meeting among interested parties, in person or by telephone, which is intended to facilitate the resolution of disputes in a cooperative manner.

9. "Interested party" means any of the following:

   a. The claimant.

   b. The claims analyst assigned to that claimant's claim.

   c. A claims supervisor.

   d. The claimant's employer or immediate supervisor.

   e. The claimant's treating doctor.

   f. A member of the bureau's legal department.

   g. Any other person the worker adviser determines appropriate.

10. "Order" means an administrative order issued pursuant to North Dakota Century Code chapter 28-32.

11. "Program" means the workers' adviser program.

12. "Worker adviser" means a person employed by the program to assist a claimant in a disputed claim.

History: Effective April 1, 1996.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

92-01-03-03. Request for assistance - Timely request for consideration or rehearing. A request to assist with the resolution of a dispute that arises from an order must be made in writing within thirty days from the date the order is issued to the claimant. An oral request is sufficient to toll the statutory time limit for requesting

reconsideration or rehearing if that request is followed by a written request for assistance which is received by the program within ten days after the oral request was made. Any written request to assist with the resolution of a dispute, including one submitted within ten days after an oral request is made under this section, is sufficient to satisfy the requirement of requesting reconsideration or rehearing of a decision made or an order issued by the bureau.

History: Effective April 1, 1996.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

92-01-03-04. Procedure for dispute resolution.

1. A claimant may contact the program for assistance with any issue or dispute at any time. Within thirty days of the date the order is issued, the claimant shall contact the bureau to request assistance with the dispute arising from the order.

2. In an attempt to resolve the dispute, the worker adviser may contact any interested parties. After oral or written contact has been made with the appropriate interested parties, the worker adviser will attempt to accomplish a mutually agreeable resolution of the dispute between the bureau and the claimant. The worker adviser may facilitate the discussion of the dispute but may not modify an informal decision or an order issued by the bureau.

3. If the dispute is not resolved, the case may be assigned to an informal benefits conference. The worker adviser will remain in contact with all interested parties until the informal benefits conference is held.

4. If a claimant has attempted to resolve the dispute and an agreement cannot be reached through the informal benefits conference, a program completion form will be completed by the worker adviser. The worker adviser will serve the program completion form on the claimant and will advise the claimant of the right to pursue the dispute through hearing or appeal. To pursue a formal rehearing of the claim, the claimant must file a petition for rehearing within thirty days after the program completion form is served on the claimant. The request must be filed pursuant to North Dakota Century Code section 28-32-14.

5. If an agreement is reached, a written copy of that agreement will be sent to the bureau's legal department for the drafting of an order based upon the agreement.

6. The program will take action within thirty days from the date that a request for assistance was received by the program from the claimant.

History: Effective April 1, 1996.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

92-01-03-05. Informal benefit review conference - Notice. If a dispute is assigned for an informal benefit review conference, the program shall provide written notice at least ten days prior to the conference to each interested party. The notice must include the date, time, and place of the conference. The ten-day notice may be waived upon agreement of the parties. The program shall provide a written specification of the issues to be considered. Each party will have an opportunity to present additional information. The informal benefit review conference will be held at the office of the program or at a place agreed upon by the parties. Any party may attend the conference by telephone.

History: Effective April 1, 1996.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27