

# **NORTH DAKOTA ADMINISTRATIVE CODE**

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**Prepared by the Legislative Council staff  
for the  
Administrative Rules Committee**

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**TITLE 33**  
**STATE DEPARTMENT OF HEALTH**



## OCTOBER 2019

### CHAPTER 33-06-01

#### 33-06-01-01. Reportable conditions.

All reports and information concerning reportable conditions are confidential and not open to inspection. The following designated reportable conditions must be reported to the state department of health by the persons designated in chapter 33-06-02. If any reportable condition is designated by an asterisk, an appropriate sample or isolate must be submitted to the division of microbiology (public health laboratory) in addition to the required report.

1. Acute flaccid myelitis.
- ~~2.~~ Anthrax\*.
- ~~2.3.~~ Arboviral infection.
- ~~3.4.~~ Botulism\*.
- ~~4.5.~~ Brucellosis\*.
- ~~5.6.~~ Campylobacteriosis.
- ~~6.7.~~ Cancer, all malignant and in situ carcinomas; in addition, all benign cancers of the central nervous system, pituitary gland, pineal gland, and craniopharyngeal duct. Carcinoma in situ of the cervix is not collected. Basal or squamous cell carcinoma is not collected unless diagnosed in the labia, clitoris, vulva, prepuce, penis, or scrotum.
- ~~7.8.~~ Candida auris\*.
- ~~9.~~ CD4 test results (all).
- ~~8.10.~~ Chickenpox (varicella).
- ~~9.11.~~ Chlamydial infections.
- ~~10.12.~~ Cholera\*.
- ~~11.~~ ~~Clostridium perfringens intoxication\*.~~
- ~~12.13.~~ Cluster of severe or unexplained illness or deaths.
- ~~14.~~ Coccidioidomycosis.

- | ~~13-15.~~ Creutzfeldt-Jakob disease.
- | ~~14-16.~~ Critical congenital heart disease (CCHD).
- | 17. Cryptosporidiosis.
- | ~~15-18.~~ Cycloporiasis.
- | 19. Diphtheria\*.
- | ~~16-20.~~ E. coli, shiga toxin-producing\*.
- | ~~17-21.~~ Fetal alcohol syndrome (FAS).
- | 22. Foodborne or waterborne outbreaks.
- | ~~18-23.~~ Giardiasis.
- | ~~19-24.~~ Glanders\*.
- | ~~20-25.~~ Gonorrhea.
- | ~~21-26.~~ Haemophilus influenzae infection (invasive infection with haemophilus influenzae isolated from blood, cerebral spinal fluid, or other normal sterile site)\*.
- | ~~22-27.~~ Hantavirus\*.
- | ~~23-28.~~ Hemolytic uremic syndrome.
- | ~~24-29.~~ Hepatitis (A\*, B, C, D, and E), including hepatitis C nucleic acid test result (detectable or nondetectable) and hepatitis C genotype results.
- | ~~25-30.~~ Human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS). (Any positive HIV test result, including gene sequencing and drug resistance patterns.) Human immunodeficiency virus (HIV) nucleic acid test result (including nondetectable).
- | ~~26-31.~~ Influenza\*.
- | ~~27-32.~~ Laboratory incidences involving the possible release of category A bioterrorism agents or novel influenza viruses into the laboratory environment.
- | ~~28-33.~~ Lead blood level results (all).
- | ~~29-34.~~ Legionellosis.
- | ~~30-35.~~ Leptospirosis.
- | 36. Listeriosis\*.
- | ~~31-37.~~ Malaria\*.
- | ~~32-38.~~ Measles (rubeola)\*.
- | ~~33-39.~~ Melioidosis\*.
- | ~~34-40.~~ Meningococcal disease (invasive infection with neisseria meningitidis isolated from blood, cerebral spinal fluid, or other normal sterile site)\*.
- | ~~35-41.~~ Mumps\*.

- | ~~36.42.~~ [Neonatal abstinence syndrome \(NAS\).](#)
- | ~~43.~~ Nipah viral infections\*.
- | ~~37.44.~~ Nosocomial outbreaks.
- | ~~38.45.~~ Novel severe acute respiratory illness\*.
- | ~~39.46.~~ Organisms resistant to carbapenem or with emerging antimicrobial resistance\*.
- | ~~40.47.~~ [Overdose.](#)
- | ~~48.~~ Pertussis.
- | ~~41.49.~~ Plague\*.
- | ~~42.50.~~ Poliomyelitis\*.
- | ~~43.51.~~ Pregnancy in a person infected with hepatitis B or HIV.
- | ~~44.52.~~ Q fever\*.
- | ~~45.53.~~ Rabies (animal or human\*).
- | ~~46.54.~~ Rubella\*.
- | ~~47.55.~~ Salmonellosis\*.
- | ~~48.56.~~ Scabies outbreaks in institutions.
- | ~~49.57.~~ Shigellosis\*.
- | ~~50.58.~~ Smallpox\*.
- | ~~51.59.~~ Staphylococcus aureus, vancomycin resistant and intermediate resistant (VRSA and VISA)\*.
- | ~~52.60.~~ Staphylococcus enterotoxin B intoxication\*.
- | ~~53.61.~~ Streptococcus pneumoniae infections (invasive infection isolated from blood, cerebral spinal fluid, or other normal sterile site)\*.
- | ~~54.62.~~ [Suicide and suicide attempts](#)
- | ~~63.~~ Syphilis.
- | ~~55.64.~~ Tetanus.
- | ~~56.65.~~ Tickborne diseases\*.
- | ~~57.66.~~ Trichinosis.
- | ~~58.67.~~ Tuberculosis (tuberculosis infection caused by Mycobacterium tuberculosis or Mycobacterium bovis)\*. [Suspected or confirmed cases of tuberculosis disease must be reported within twenty-four hours. Laboratories that receive specimens for tuberculosis testing shall report all results obtained by an appropriate procedure. This includes all smear results for acid-fast bacilli, results of cultures to look for M. tuberculosis complex, and results of rapid methodologies, including nucleic acid amplifications which are performed when M. tuberculosis complex is suspected \(only via electronic laboratory reporting\). Positive results of tests performed by purified protein derivative antigen or by any other diagnostic test approved for the purpose of](#)

identifying tuberculosis infection, (i.e. interferon gamma release assay) with corresponding values as available.

~~59.68.~~ Tularemia\*.

~~60.69.~~ Tumors of the central nervous system.

~~61.70.~~ Typhoid fever\*.

~~62.71.~~ Unexplained or emerging critical illness or death.

~~— 63. — Unusual cluster of severe or unexplained illnesses or deaths.~~

~~64.72.~~ Vibriosis\*.

~~65.73.~~ Violent death.

74. Viral hemorrhagic fevers.

~~66.75.~~ Weapons of mass destruction suspected event.

~~67.76.~~ Yellow fever\*.

**History:** Amended effective May 1, 1984; December 1, 1986; January 1, 1988; January 1, 1989; October 1, 1990; January 1, 1991; February 1, 1992; May 1, 1994; January 1, 1995; July 1, 1996; February 1, 2000; August 1, 2002; March 1, 2003; July 1, 2004; April 1, 2007; January 1, 2011; January 1, 2018; October 1, 2019.

**General Authority:** NDCC 23-07-01

**Law Implemented:** NDCC 23-07-01



## CHAPTER 33-44-01 MEDICAL MARIJUANA

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**33-44-01-01. Definitions.**

In this chapter, unless the context otherwise requires:

1. "Activation time" means the amount of time it is likely to take for an individual to begin to feel the effects of ingesting or inhaling usable marijuana.
2. "Adverse reaction" means an unwanted, unexpected, or dangerous effect caused by the administration of usable marijuana dispensed pursuant to North Dakota Century Code chapter 19-24.1.
3. "Analyte" means a component, substance, or chemical or microbiological constituent that is of interest in an analytical procedure or test.
4. "Batch" means a quantity of dried leaves and flowers from a harvest lot, a quantity of cannabinoid concentrate, or medical cannabinoid product from a process lot.
5. "Compliance test" means a test required by these rules to be performed by a laboratory selected by the department in order to allow the transfer or sale of usable marijuana.
6. "Container" means a sealed, hard- or soft-bodied receptacle in which usable marijuana is placed.
7. "Container ~~unique~~-identification number" means the ~~unique~~-identification number that was generated by the manufacturing facility at the time the usable marijuana was packaged and labeled for sale to the dispensary.
8. "Cotyledons" means an embryonic leaf of a plant, one or more of which are the first leaves to appear.
9. "Date of harvest" means the date the mature marijuana plants in a harvest lot were removed from the soil or other growing media. If the harvest occurred on more than one day, the "date of harvest" is the day the last mature marijuana plant in the harvest lot was removed from the soil or other growing media.
10. "Degradation compound" or "Pesticide degradate" means a resultant product from the transformation of a parent compound to a product with different physical and chemical properties, the fate and significance of which, is altered due to the structural changes.
11. "Harvest lot" means a specifically identified quantity of the same strain of marijuana that is cultivated utilizing the same growing practices, harvested within a seventy-two-hour period at the same location, and cured under uniform conditions.
12. "Hazardous waste" means the same as defined in North Dakota Century Code chapter 23-20.3.
13. "Laboratory" means a laboratory selected by the department in accordance with section 33-44-01-36 to sample and conduct tests in accordance with these rules.

14. "Medical marijuana waste" means the same as defined in North Dakota Century Code chapter 19-24.1 ~~and also includes any wastewater generated during production and processing.~~
15. "Net weight" means the gross weight minus the tare weight of the packaging.
16. "Parent compound" means the original molecular structure from which other compounds can be derived through a chemical reaction or natural breakdown process.
17. "Pediatric symbol" means the image, established by the department and made available to manufacturing facilities, indicating the product complies with the pediatric medical marijuana maximum concentration limit as defined in North Dakota Century Code chapter 19-24.1.
18. "Plant" means a marijuana plant that has produced cotyledons or a cutting of a marijuana plant that has produced cotyledons.
19. "Process lot" means any amount of:
  - a. Cannabinoid concentrate of the same type and processed within a forty-eight-hour period using the same extraction methods, standard operating procedures, and batches, not to exceed three, of the same strain from the same or a different harvest lot; or
  - b. Medical cannabinoid product of the same type and processed within a forty-eight-hour period using the same ingredients, standard operating procedures, and ~~batches from the same or a different harvest lot or a~~ process lot or process lots, not to exceed three, of cannabinoid concentrate as defined in subsection a.
20. "Product identity" means a common name of the product that is contained in the package.
21. "Remediation" means a process used by a manufacturing facility to remedy a lot or batch that has failed testing.
22. "Sterilization" means the removal of all micro-organisms and other pathogens from usable marijuana by treating it with approved chemicals or subjecting it to high heat.
23. "Tentatively identified compounds" means compounds detected in a sample using gas chromatography mass spectrometry or liquid chromatography mass spectrometry that are not among the target analytes for the residual solvent analysis and pesticide and mycotoxin analysis.
24. "Test sample" means anything collected by a laboratory from a compassion center for testing.
25. "Unit of sale" means an amount of usable marijuana commonly packaged in a container for transfer to a registered qualifying patient or registered designated caregiver, or capable of being packaged in a container for transfer to a registered qualifying patient or registered designated caregiver.
26. "Universal symbol" means the image, established by the department and made available to manufacturing facilities, indicating the product contains marijuana.
27. "Water activity" means a measure of the free moisture in usable marijuana and is the quotient of the water vapor pressure of the substance divided by the vapor pressure of pure water at the same temperature, and is indicated by the symbol  $a_w$ .
28. "Written notice" means a notice provided to the department via letter, electronic mail, or other electronic form or medium made available on the department's website.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General authority:** NDCC 19-24.1-01

**33-44-01-08. Compassion center inventory limits.**

1. ~~Except as otherwise provided by this section, a manufacturing facility may not possess more than one thousand plants, regardless of the stage of growth.~~ A manufacturing facility shall grow an amount of marijuana sufficient to meet the qualifying patient population demands. A manufacturing facility may possess ~~an additional~~ up to fifty plants for the ~~exclusive~~ purpose of department-authorized research and development related to production and processing. Plants for research and development shall:
  - a. Be included in inventory;
  - b. Be located in a restricted area separate from the restricted area containing plants used for producing and processing of usable marijuana; and
  - c. Not be used in the production and processing of usable marijuana that is sold to a dispensary for patient consumption unless authorized by the department in writing.
2. A manufacturing facility with a registration certificate may use additional structures located within five hundred feet [152.40 meters] of the location described in the original application. Prior to using additional structures, the manufacturing facility shall submit a written request to the department. The written request must include the reason the structures are necessary, verification the additional structures do not jeopardize public health or safety, and evidence from the appropriate local government official that the additional structures are at least one thousand feet [304.80 meters] from a property line of a pre-existing public or private school. The department shall approve or deny a request within thirty calendar days. The department shall deny a request if the department makes an affirmative finding the use of additional structures would jeopardize public health or safety or the additional structures are within one thousand feet [304.80 meters] of a property line of a pre-existing public or private school.
3. A dispensary may not possess more than three thousand five hundred ounces [99.22 kilograms] of usable marijuana at any time, regardless of formulation.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-17, 19-24.1-24

**Law Implemented:** NDCC 19-24.1-17, 19-24.1-24

**33-44-01-09. Use of pesticides prohibited.**

~~The use of pesticides is prohibited. A compassion center may not use pesticides, as defined by the environmental protection agency, in the production, processing, or storage of marijuana. Pesticides include:~~

- ~~1. Organochlorines.~~
- ~~2. Organophosphates.~~
- ~~3. Carbamates.~~
- ~~4. Insecticidal, fungicidal, or growth regulatory compounds.~~ Except for minimum-risk pesticides identified in North Dakota Century Code section 4.1-34-10, the use of pesticides, as defined in North Dakota Century Code section 4.1-34-01, in the production, processing, or storage of marijuana is prohibited. Prior to using any minimum-risk pesticide a compassion center must receive written approval from the department.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-22

**Law Implemented:** NDCC 19-24.1-22

**33-44-01-12. Restricted access areas.**

1. Except as provided in section 33-44-01-13, compassion center restricted access areas include:
  - a. All areas containing marijuana, usable marijuana, and medical marijuana waste.
  - b. All areas used for production and processing.
2. A compassion center shall use an electronic controlled access system to limit entrance to all restricted access areas of its facility.
  - a. An electronic controlled access system must:
    - (1) Limit access to authorized individuals.
    - (2) Track specific personnel entry and exit times.
    - (3) Lock down the facility in the event of a security threat.
    - (4) Store data for retrieval.
    - (5) Remain operable in the event of power failure.
    - (6) Enable remote administration.
  - b. A compassion center immediately shall submit stored controlled-access-system data to the department upon request.
  - c. Restricted access areas must be identified with a sign that states: "Do Not Enter - Restricted Access Area - Access Limited to Authorized Personnel Only."
3. Individuals authorized to enter restricted access areas include:
  - a. Compassion center agents;
  - b. Laboratory agents;
  - c. Authorized department personnel; ~~and~~
  - d. Individuals accompanied by a compassion center agent when the compassion center agent has received written authorization from authorized department personnel; and
  - e. Individuals accompanied by authorized department personnel.
4. A compassion center shall maintain documentation of access to restricted areas for individuals included in paragraphs b, c, ~~and d~~, and e of subsection 3. The documentation must include date of entry, time of entry, time of exit, name of individual, reason for access, and any other information required by the department. The documentation must be retained for at least three years.
5. Law enforcement, fire personnel, or emergency medical service professionals may enter restricted access areas in the event of an emergency requiring immediate action.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-25

**Law Implemented:** NDCC 19-24.1-25

**33-44-01-13. Dispensary display areas.**

1. A dispensary may have a display area where usable marijuana is displayed in enclosed locked cases accessible only by compassion center agents. The purpose of the display area is to provide registered qualifying patients and registered designated caregivers the opportunity to view usable marijuana and receive education regarding its use. Usable marijuana may not be visible from the street or other public areas.
2. Individuals authorized to enter dispensary display areas include:
  - a. Registered qualifying patients;
  - b. Registered designated caregivers;
  - c. Compassion center agents;
  - d. Authorized department personnel; ~~and~~
  - e. Individuals accompanied by a compassion center agent when the compassion center agent has received written authorization from authorized department personnel; and
  - f. Individuals accompanied by authorized department personnel.
3. Before allowing an individual to enter a dispensary display area, the dispensary shall verify the validity of a cardholder's registry identification card.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-25

**Law Implemented:** NDCC 19-24.1-25

**33-44-01-17. Surveillance requirements.**

1. To prevent unauthorized access to marijuana and usable marijuana, the compassion center shall have video surveillance equipment to deter the unauthorized entrance into restricted access areas.
  - a. The compassion center shall operate, monitor, and maintain in good working order a closed-circuit television surveillance system on all of its premises, which must operate at all times and visually record:
    - (1) All phases of production and processing.
    - (2) All compassion center points of entry and exit, sales and display areas, ~~storage facilities,~~ and garages.
    - (3) The entrance to the video surveillance room.
    - (4) Any parking lot, which must have appropriate lighting for the normal conditions of the area under surveillance.
  - b. Video surveillance systems must:
    - (1) Capture clear and certain identification of any person entering or exiting a compassion center.
    - (2) Have the ability to produce a clear, color, still photo either live or from a recording.

- (3) Have an embedded date-and-time stamp on all recordings which must be synchronized and not obscure the picture.
- (4) Continue to operate during a power outage.
- c. Video recording specifications include:
  - (1) A video recording must export still images in an industry standard image format, including .jpg, .bmp, and .gif.
  - (2) Exported video must be archived in a proprietary format that ensures authentication and guarantees the recorded image has not been altered.
  - (3) Exported video must be saved in an industry standard file format that can be played on a standard computer operating system.
  - (4) Upon completion of the required retention period, all recordings must be erased or destroyed before disposal.
- 2. The compassion center shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.
- 3. The compassion center shall ensure that twenty-four hour recordings from all video cameras are:
  - a. Available for viewing by the department through a secure internet connection.
  - b. Retained for a period of at least ninety calendar days during the first year of operation, and upon department approval, for at least sixty calendar days thereafter.
  - c. Maintained free of alteration or corruption.
  - d. Retained longer if the compassion center is given notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

**History:** Effective April 1, 2018; [amended effective October 1, 2019](#).

**General Authority:** NDCC 19-24.1-25

**Law Implemented:** NDCC 19-24.1-25

**33-44-01-18. Alarm system requirements.**

- 1. A compassion center shall install and maintain a professionally monitored security alarm system that provides intrusion and fire detection of all:
  - a. Facility entrances and exits.
  - b. Rooms with exterior windows.
  - c. Rooms with exterior walls.
  - d. Roof hatches.
  - e. Skylights.

~~f. Storage rooms.~~

- 2. A security alarm system means a device or series of devices that summons law enforcement personnel during, or as a result of, an alarm condition. Devices may include:



- a. Hardwired systems and systems interconnected with a radio frequency method, such as cellular or private radio signals that emit or transmit a remote or local audio, visual, or electronic signal.
  - b. Motion detectors.
  - c. Pressure switches.
  - d. A duress alarm.
  - e. A panic alarm.
  - f. A holdup alarm.
  - g. An automatic voice dialer.
  - h. A failure notification system that provides an audio, text, or visual notification of any failure in the surveillance system.
3. A compassion center's security alarm system and all devices must continue to operate during a power outage.
  4. The compassion center shall test the security alarm system and all devices on a monthly basis and maintain a record of all tests.
  5. The compassion center's security alarm system must be inspected and all devices tested annually by a qualified alarm vendor.

**History:** Effective April 1, 2018; [amended effective October 1, 2019](#).

**General Authority:** NDCC 19-24.1-25

**Law Implemented:** NDCC 19-24.1-25

### **33-44-01-22. Compassion center [and laboratory](#) incidents.**

1. Compassion centers [and the laboratory](#) shall contact 911 in the event of an emergency and contact law enforcement or 911 to report criminal activities.
2. Compassion centers [and the laboratory](#) shall provide the department with written notice, within twenty-four hours, of any of the following:
  - a. A breach of security;
  - b. Failures of, or tampering with, security and surveillance equipment, cameras, or recordings;
  - c. Power failures lasting longer than two hours;
  - d. Embezzlement or fraud;
  - e. Contacting 911 or contact with law enforcement;
  - f. Incidents that occur while transporting marijuana, usable marijuana, and medical marijuana waste; and
  - g. Attempts to obtain marijuana or usable marijuana in a manner not prescribed by North Dakota Century Code chapter 19-24.1 and these rules.

**History:** Effective April 1, 2018; [amended effective October 1, 2019](#).

**General Authority:** NDCC 19-24.1-25



**Law Implemented:** NDCC 19-24.1-25

**33-44-01-24. Strain or brand names.**

A manufacturing facility may not use strain or brand names containing any words that refer to products commonly associated with minors, marketed ~~by~~to minors, or any names that are false or misleading.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

**33-44-01-25. Usable marijuana packaging.**

All usable marijuana packaging used by a manufacturing facility must be approved by the department. A manufacturing facility shall package all usable marijuana intended for distribution according to the following standards:

1. Usable marijuana containers must be:
  - a. Plain.
  - b. Tamper-evident.
  - c. Child-resistant.
2. Usable marijuana must be packaged to minimize its appeal to children.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

**33-44-01-26. Manufacturing facility labeling.**

1. A manufacturing facility shall label all usable marijuana in accordance with the following before their sale or transfer to a dispensary:
  - a. A container holding dried leaves and flowers must include the following information:
    - (1) Manufacturers' business or trade name and registry certification number;
    - (2) Container ~~unique~~-identification number;
    - (3) Harvest lot number;
    - (4) Date of harvest;
    - (5) Name of strain;
    - (6) Net weight in United States customary and metric units;
    - (7) Concentration of total tetrahydrocannabinol, ~~tetrahydrocannabinolic acid~~, and total cannabidiol;
    - (8) Activation time expressed in words or through a pictogram;
    - (9) Expiration date;
    - (10) Universal symbol; and

- (11) Consumer warnings that state:
  - (a) "This product is not approved by the Food and Drug Administration to treat, cure, or prevent any disease."
  - (b) "For use by North Dakota registered qualifying patients only."
  - (c) "Keep out of reach of children."
  - (d) "It is illegal to drive or to be in actual physical control of a motor vehicle while under the influence of marijuana."
  
- b. A container holding a cannabinoid concentrate must include the following information:
  - (1) Manufacturing facility's business or trade name and registry certification number;
  - (2) Container ~~unique~~-identification number;
  - (3) Process lot number;
  - (4) Product identity;
  - (5) Date the concentrate was made;
  - (6) Net weight or volume in United States customary and metric units;
  - (7) If applicable, serving size and number of servings per container or amount suggested for use by the consumer or patient at any one time;
  - (8) Concentration or amount of tetrahydrocannabinol, and the concentration or amount of cannabidiol, by weight or volume in each amount suggested for use and in the container;
  - (9) Activation time, expressed in words or through a pictogram;
  - (10) Expiration date;
  - (11) Universal symbol;
  - (12) Pediatric symbol, if applicable; and
  - (13) Consumer warnings that state:
    - (a) "This product is not approved by the Food and Drug Administration to treat, cure, or prevent any disease."
    - (b) "For use by North Dakota registered qualifying patients only."
    - (c) "Keep out of reach of children."
    - (d) "It is illegal to drive or to be in actual physical control of a motor vehicle while under the influence of marijuana."
  
- c. A container holding a medical cannabinoid product must include the following information:
  - (1) Manufacturers' business or trade name and registry certification number;
  - (2) Container ~~unique~~-identification number;

- (3) Process lot number;
  - (4) Product identity;
  - (5) Date the product was made;
  - (6) Net weight or volume in United States customary and metric units;
  - (7) Serving size and number of servings per container;
  - (8) Concentration or amount of tetrahydrocannabinol, and the concentration or amount of cannabidiol, by weight or volume in each serving and in each container;
  - (9) List of ingredients in descending order or predominance by weight or volume used to process the medical cannabinoid product;
  - (10) Activation time, expressed in words or through a pictogram;
  - (11) Expiration date;
  - (12) Universal symbol;
  - (13) Pediatric symbol, if applicable; and
  - (14) Consumer warnings that state:
    - (a) "This product is not approved by the Food and Drug Administration to treat, cure, or prevent any disease."
    - (b) "For use by North Dakota registered qualifying patients only."
    - (c) "Keep out of reach of children."
    - (d) "It is illegal to drive or to be in actual physical control of a motor vehicle while under the influence of marijuana."
2. Usable marijuana labels required in accordance with this section must be no smaller than eight point, arial or calibri, font. If, due to the size of the container, sufficient space does not exist for a label containing all of the required information, the manufacturing facility may:
- a. Use a peel-back or accordion label if, the peel-back or accordion label is easily identified as containing the required information; or
  - b. Reduce the size of the required information to six point font.

**History:** Effective April 1, 2018; [amended effective October 1, 2019](#).

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

### **33-44-01-36. Laboratory procurement process.**

The department may ~~enter a~~ contract with a laboratory or laboratories to conduct random quality sampling testing of a compassion center's marijuana and usable marijuana. The department shall procure the laboratory testing services in accordance with North Dakota Century Code chapter 54-44.4. An awarded laboratory must be properly accredited as determined by the department.

**History:** Effective April 1, 2018; [amended effective October 1, 2019](#).

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

### 33-44-01-42. Compliance testing requirements for dried leaves and flowers.

~~1. A manufacturing facility shall have every batch from a harvest lot of dried leaves and flowers tested for pesticides and degradation compounds in accordance with section 33-44-01-47.~~

~~2. In addition to testing required in subsection 1, a~~ A manufacturing facility shall have every batch from a harvest lot of dried leaves and flowers, to be packaged in a container for transfer to a dispensary, tested for the following:

~~a.1. Pesticides and degradation compounds in accordance with section 33-44-01-47.~~

2. Microbiological contaminants and mycotoxins in accordance with section 33-44-01-48.

~~b.3. Heavy metals in accordance with section 33-44-01-48.1.~~

4. Water activity and moisture content in accordance with section 33-44-01-50.

~~e.5. Concentration in accordance with section 33-44-01-51.~~

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

### 33-44-01-43. Compliance testing requirements for cannabinoid concentrates.

1. A manufacturing facility shall have every process lot of cannabinoid concentrate, to be packaged in a container for transfer to a dispensary, tested for the following:

a. Pesticides and degradation compounds in accordance with section 33-44-01-47.

b. Microbiological contaminants and mycotoxins in accordance with section 33-44-01-48.

c. Heavy metals in accordance with section 33-44-01-48.1.

d. Solvents in accordance with section 33-44-01-49.

~~d.e.~~ Concentration in accordance with section 33-44-01-51.

~~2. A manufacturing facility shall have every process lot of cannabinoid concentrate intended for use in processing a medical cannabinoid product tested for:~~

~~a. Pesticides and degradation compounds in accordance with section 33-44-01-47.~~

~~b. Microbiological contaminants and mycotoxins in accordance with section 33-44-01-48.~~

~~c. Solvents in accordance with section 33-44-01-49.~~

~~3. A cannabinoid concentrate may not be used in processing a medical cannabinoid product unless the requirements of testing in subsection 2 have been met.~~

~~4. A manufacturing facility is exempt from testing for solvents under this section if the manufacturing facility did not use any solvent~~ or the department provides the manufacturing facility with a written exemption if the manufacturing facility uses a closed loop carbon dioxide extraction method.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

### **33-44-01-44. Compliance testing requirements for medical cannabinoid products.**

A manufacturing facility shall have every process lot of a medical cannabinoid product, to be packaged in a container for transfer to a dispensary, tested for the following:

1. Pesticides and degradation compounds in accordance with section 33-44-01-47.
2. Microbiological contaminants and mycotoxins in accordance with section 33-44-01-48.
- ~~2.3.~~ Heavy metals in accordance with section 33-44-01-48.1.
4. Solvents in accordance with section 33-44-01-49.
5. Concentration in accordance with section 33-44-01-51.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

#### **33-44-01-44.1. Terpene analysis.**

Upon a manufacturing facility's request, a terpene analysis may be performed by a laboratory selected by the department as described in section 33-44-01-36. The manufacturing facility shall pay all costs associated with a terpene analysis. A manufacturing facility may include terpenoid profile information on the label of a container holding dried leaves and flowers, a cannabinoid concentrate, or medical cannabinoid product only when a terpene analysis is performed under this section.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

### **33-44-01-46. Manufacturing facility requirements for labeling, storing, and securing usable marijuana batches.**

When samples are taken from a harvest or process lot batch, a manufacturing facility shall:

1. Ensure the batch is labeled with the following information:
  - a. The manufacturing facility's name;
  - b. The harvest lot or process lot unique identification number;
  - c. The name of the laboratory that took samples;
  - d. The unique identification sample numbers ~~provided by the laboratory agents~~; and
  - e. The date the samples were taken.
2. Store and secure the batch in a manner that prevents the product from being tampered with or transferred prior to required tests being completed.
3. Be able to easily locate a batch stored and secured under subsection 2 and provide that location to the department or a laboratory upon request.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

**33-44-01-48.1. Standards for heavy metals compliance testing.**

A batch fails heavy metals testing if the presence of one of the following metals, at a minimum, is above the following listed limit:

	<b><u>Parts per Million (ppm)</u></b>
<u>Inorganic arsenic</u>	<u>0.4</u>
<u>Cadmium</u>	<u>0.3</u>
<u>Lead</u>	<u>1.0</u>
<u>Mercury</u>	<u>0.2</u>

**History:** Effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

**33-44-01-51. Standards for concentration compliance testing.**

1. Usable marijuana concentration testing must include:
  - a. Tetrahydrocannabinol (THC).
  - b. Tetrahydrocannabinolic acid (THCA).
  - c. Cannabidiol (CBD).
  - d. Cannabidiolic acid (CBDA).
2. The total tetrahydrocannabinol and total cannabidiol must be calculated as follows:
  - a. Total tetrahydrocannabinol, where M is the mass or mass fraction of delta-9 tetrahydrocannabinol or delta-9 tetrahydrocannabinolic acid:
$$M \text{ total delta-9 THC} = \text{delta-9 THC} + (0.877 \times M \text{ delta-9 THCA})$$
  - b. Total cannabidiol, where M is the mass or mass fraction of cannabidiol and cannabidiolic acid:
$$M \text{ total CBD} = M \text{ CBD} + (0.877 \times M \text{ CBDA})$$
3. Test results must report ~~total~~ tetrahydrocannabinol ~~and total~~, tetrahydrocannabinolic acid, cannabidiol, and cannabidiolic acid content by dry weight calculated as follows:
  - a. ~~P total~~ THC(dry) = ~~P total~~ THC(wet) / [1-(P moisture/100)].
  - b. P THCA(dry) = P THCA(wet) / [1-(P moisture/100)].
  - c. ~~P total~~ CBD(dry) = ~~P total~~ CBD(wet) / [1-(P moisture/100)].
  - d. P CBDA(dry) = P CBDA(wet) / [1-(P moisture/100)].
4. The concentration test fails if the total amount of tetrahydrocannabinol and tetrahydrocannabinolic acid, as calculated pursuant to this section, exceeds the maximum concentration or amounts permitted in North Dakota Century Code chapter 19-24.1.
5. The concentration test fails if the concentration amount identified by the laboratory varies from the concentration amount identified by the manufacturing facility, if known, by more than plus or minus fifteen percent.

6. The concentration test fails if the tetrahydrocannabinol or cannabidiol content of a medical cannabinoid product is determined through testing not to be homogenous. A medical cannabinoid product is considered not to be homogenous if ten percent of the infused portion of the medical cannabinoid product contains more than twenty percent of the total tetrahydrocannabinol or cannabidiol contained within the entire medical cannabinoid product.
7. If the samples do not pass testing standards for concentration, the manufacturing facility must comply with section 33-44-01-52.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

### **33-44-01-52. Failed test samples.**

1. If a sample fails any test, the manufacturing facility may submit a written request to the department for a reanalysis. The request must be received by the department within seven calendar days from the date the laboratory sent notice of the failed test to the manufacturing facility. The department, in consultation with the laboratory, shall determine whether a reanalysis will be performed on the samples held by the laboratory or a new sample will be selected from the batch. The reanalysis must be completed by the laboratory within thirty days from the date the reanalysis request was received.
2. If a sample fails a test or a reanalysis under subsection 1:
  - a. The batch may be remediated or sterilized in accordance with this section; or
  - b. If the batch is not or cannot be remediated or sterilized under this section, the batch must be disposed of in accordance with section 33-44-01-15.

3. ~~A manufacturing facility shall comply with the following requirements when a sample fails to meet the standards for pesticides and degradation compounds testing:~~

~~a. If a sample from a batch of dried leaves and flowers fails pesticide or degradation compound testing, the batch may not be remediated and must be disposed of as ordered by the department or the department of agriculture. An affected or contaminated batch may not be destroyed without obtaining written permission from the department or the department of agriculture.~~

~~b. If a batch from a processing lot using dried leaves and flowers that originally passed pesticide and degradation compound testing under section 33-44-01-47 has a sample failing pesticide and degradation compound testing, the batch may be remediated if written approval from the department is obtained prior to remediation.~~

~~c. A batch that is remediated in accordance with subdivision b of subsection 6 must be sampled and tested in accordance with these rules.~~

~~d. A batch that fails pesticide and degradation compound testing after undergoing remediation in accordance with subdivision b of subsection 6 is considered contaminated and must be disposed of as ordered by the department or the department of agriculture. A contaminated batch may not be destroyed without obtaining written permission from the department or the department of agriculture.~~  
If a sample from a batch of dried leaves and flowers, cannabinoid concentrate, or cannabinoid product fails pesticide or degradation compound testing, the batch may not be remediated and must be disposed of as ordered by the department or the department of agriculture. An affected or contaminated batch may not be destroyed without obtaining written permission from the department or the department of agriculture.



4. A manufacturing facility shall comply with the following requirements when a sample fails to meet the standards for microbiological contaminant or mycotoxin testing:
  - a. If a sample from a batch of dried leaves and flowers fails microbiological contaminant or mycotoxin testing, the batch may be used to make a cannabinoid concentrate if:
    - (1) ~~The processing method effectively sterilizes the batch, such as a method using a hydrocarbon-based solvent or a carbon dioxide closed loop system; or~~ The batch is not combined with another batch of dried leaves and flowers to process a cannabinoid concentrate; and
    - (2) The processing method effectively sterilizes the batch, such as a method using a hydrocarbon-based solvent or a carbon dioxide closed loop system, or the processing method selectively removes the mycotoxins from the batch.
  - b. If a sample from a batch of a cannabinoid concentrate fails microbiological contaminant or mycotoxin testing, the batch may be further processed if:
    - (1) The processing method effectively sterilizes the batch, such as a method using a hydrocarbon-based solvent or a carbon dioxide closed loop system; or
    - (2) The processing method selectively removes the mycotoxins from the batch.
  - c. If a sample from a batch of a medical cannabinoid product fails microbiological contaminant or mycotoxin testing, the batch may be remediated if written approval from the department is obtained prior to remediation.
  - d. A batch that is remediated in accordance with subdivision a, b, or c of subsection ~~34~~ must be sampled and tested in accordance with these rules.
  - e. A batch that fails microbiological contaminant or mycotoxin testing after undergoing remediation in accordance with subdivision a, b, or c of subsection ~~34~~ must be disposed of in accordance with section 33-44-01-15.
5. If a sample from a batch of dried leaves and flowers, cannabinoid concentrate, or cannabinoid product fails heavy metals testing, the batch may be remediated if written approval from the department is obtained prior to remediation. A batch that is remediated must be sampled and tested in accordance with these rules. A batch that fails heavy metals testing after undergoing remediation must be disposed of in accordance with section 33-44-01-15.
- ~~6.~~ 6. A manufacturing facility shall comply with the following requirements when a sample fails to meet the standards for solvent testing:
  - a. If a sample from a batch fails solvent testing, the batch may be remediated using procedures that would reduce the concentration of solvents to less than the action level established in these rules.
  - b. A batch that is remediated in accordance with subdivision a of subsection ~~46~~ must be sampled and tested in accordance with these rules.
  - c. A batch that fails solvent testing after undergoing remediation in accordance with subdivision a must be disposed of in accordance with section 33-44-01-15.
- ~~6.7.~~ 6.7. A manufacturing facility shall comply with the following requirements when a sample fails to meet the standards for water activity and moisture testing:
  - a. If a sample from a batch of dried leaves and flowers fails for water activity or moisture testing, the batch from which the sample was taken may:



- (1) Be used to make a cannabinoid concentrate or a medical cannabinoid product and must comply with testing requirements established in these rules; or
  - (2) Continue to dry or cure.
- b. A batch that undergoes additional drying or curing as described in paragraph 2 of subdivision a must be sampled and tested in accordance with these rules.

**7.8.** A manufacturing facility shall comply with the following requirements when a sample fails to meet the standards for concentration testing:

- a. A batch that has a sample failing concentration testing under subsection 4 of section 33-44-01-51 may be remediated to meet the concentration limits permitted in North Dakota Century Code chapter 19-24.1.
- b. If a sample from a batch of pediatric medical marijuana fails concentration testing, the manufacturing facility may use the batch for nonpediatric usable marijuana rather than remediating the pediatric medical marijuana in accordance with subdivision a. No additional testing is required if the manufacturing facility does not label the usable marijuana for pediatric use and does no further processing with a batch of pediatric medical marijuana failing concentration testing. Any usable marijuana processed with a batch from a failed pediatric medical marijuana concentration test must be sampled and tested in accordance with these rules.
- c. A batch that has a sample failing concentration testing under subsection 5 of section 33-44-01-51 may be remediated or the manufacturing facility may use the concentration test results of the laboratory for labeling purposes.
- d. A batch that has a sample failing concentration testing under subsection 6 of section 33-44-01-51 may be remediated.
- e. A batch that is remediated in accordance with subdivision a, c, or d must be sampled and tested in accordance with these rules.

**8.9.** A manufacturing facility shall, as applicable:

- a. Have detailed written procedures for remediation processes to be used pursuant to this section.
- b. Document all remediation processes used pursuant to this section.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

### **33-44-01-55. Manufacturing facility quality control and quality assurance program.**

1. A manufacturing facility shall develop and follow a written quality control and quality assurance program. The program must be established to protect qualifying patient health and implemented in a manner to assist in complying with testing required in sections 33-44-01-42, 33-44-01-43, and 33-44-01-44. A manufacturing facility is not prohibited by these rules to test marijuana and usable marijuana as part of a quality control and quality assurance program.
2. A quality control and quality assurance program must include an assessment of the profile of the active ingredients, including expiration date, and the presence of inactive ingredients and contaminants. Testing results must be used to determine appropriate conditions and expiration dates.

3. A manufacturing facility shall develop and follow written procedures for sampling marijuana and usable marijuana. Procedures must be developed related to sampling methods, sample collection, and documentation of sampling. Test results from random samples must be retained for at least three years.
4. The manufacturing facility shall develop and follow written procedures for performing stability testing of usable marijuana to determine product expiration date. ~~If stability testing has not been completed within one year of production, a manufacturing facility may assign a tentative expiration date based on available stability information. After the manufacturing facility verifies the tentative expiration date, or determines the appropriate expiration date, the manufacturing facility shall include the expiration date on each batch of marijuana or usable marijuana.~~ Once an expiration date has been determined through testing described in subsection 5, a manufacturing facility must perform periodic stability testing to verify expiration dates.
5. If stability testing has not been completed within one year of production, a manufacturing facility may assign a tentative expiration date based on available stability information. Stability testing is to include, at a minimum, an assessment of microbiological contaminants and mycotoxins, heavy metals, and concentration. When applicable, the stability testing must include water activity and moisture content or solvents. If an expiration date is one year or less, at a minimum, a stability test must be performed once before fifty percent of the period has expired and at the end of the expiration date. If an expiration date is more than one year, at a minimum, a stability test must be performed at no less than six-month intervals and at the end of the expiration date. After the manufacturing facility verifies the tentative expiration date, or determines the appropriate expiration date, the manufacturing facility shall include the expiration date on each batch of marijuana or usable marijuana.
6. A manufacturing facility shall retain a uniquely labeled reserve sample representing each ~~batch of usable marijuana~~ harvest lot, process lot of cannabinoid concentrate to be packaged in a container for transfer to a dispensary, and process lot of medical cannabinoid product for at least one year following the ~~batch's~~ expiration date. The reserve sample must be stored in the same immediate container-closure system the usable marijuana is packaged in for dispensaries, or in one that has similar characteristics. The reserve sample must consist of at least twice the quantity necessary to perform all required tests.

**History:** Effective April 1, 2018; amended effective October 1, 2019.

**General Authority:** NDCC 19-24.1-36

**Law Implemented:** NDCC 19-24.1-36

**TITLE 45**  
**INSURANCE, COMMISSIONER OF**



**OCTOBER 2019**

**CHAPTER 45-01-01**

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

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

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

**History:** Amended effective January 1, 1982; August 1, 1983; March 1, 1986; January 1, 1992; February 1, 1993; April 1, 1994; June 1, 2003; January 1, 2009; [October 1, 2019](#).

**General Authority:** NDCC 28-32-02.1

**Law Implemented:** NDCC 28-32-02.1

## CHAPTER 45-02-02

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

#### 1. Resident insurance producers' applications.

- a. ~~An~~A complete application must be completed in accordance with the instruction sheet and submitted either electronically or with a paper filing on a commissioner-approved application form.
- b. An applicant licensed in another state within the preceding ninety days who moves to this state must provide, with the application, proof of clearance from the state in which the insurance producer is currently or was most recently licensed as a resident insurance producer.
- c. An application form is required to add an additional line of insurance.
- d. Every application submitted to the department through either a paper or electronic filing must be accompanied by the appropriate fee made payable to either the commissioner or the commissioner's designee.

#### 2. Nonresident insurance producers' applications.

- a. ~~An~~A complete application for a nonresident insurance producer's license must comply with subdivisions a, c, and d of subsection 1 and must contain a written designation of the commissioner and the commissioner's successors in office as that insurance producer's true and lawful attorney for purposes of service of process.
- b. An applicant for a nonresident insurance producer's license must have the state, which issued the agent's resident license, supply to the department a certificate showing the lines for which the agent is licensed and eligible to write in that state. This certification may be submitted by the national association of insurance commissioners' producer data base.

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

#### 4. Consultants' applications.

- a. An application for a consultant's license must be submitted in accordance with the instruction sheet provided by the department and submitted on the appropriate form.
- b. No person holding a license as an insurance producer or surplus lines insurance producer may obtain and simultaneously hold a license as a consultant. If the applicant holds such licenses at the time of application, the licenses must be canceled prior to obtaining a consultant's license.

#### 5. Temporary license applications.

- a. An application for a temporary insurance producer's license must be submitted in accordance with section 45-02-02-02.
- b. The application must be accompanied by a written statement of the reasons for requesting the issuance of a temporary license.
- c. A temporary license will not be granted for the sole reason that the applicant has failed to pass the insurance producers' examination and desires to be licensed until such time as a passing examination score is obtained.

**History:** Effective September 1, 1983; amended effective October 1, 1984; January 1, 1987; April 1, 1996; January 1, 2000; December 1, 2001; January 1, 2008; January 1, 2016; [October 1, 2019](#).

**General Authority:** NDCC 26.1-26-49

**Law Implemented:** NDCC 26.1-26-12, 26.1-26-13

## CHAPTER 45-02-04

### 45-02-04-01. Purpose.

Insurance continuing education courses must promote educational activities that advance one's professional expertise and keep the individual abreast with the insurance industry. Routine meetings, luncheons, and gatherings not advertised and developed as insurance continuing education events will not qualify for insurance continuing education credit. This does not apply to industry, regulatory, or legislative meetings held by or on behalf of a professional insurance association in conjunction with North Dakota Century Code section 26.1-26-31.9.

**History:** Effective July 1, 1986; amended effective January 1, 2008; October 1, 2019.

**General Authority:** NDCC 26.1-26-49

**Law Implemented:** NDCC 26.1-26-49



**ARTICLE 45-03**  
**REGULATION OF INSURANCE COMPANIES**

Chapter	
45-03-01	Solicitation of Proxies, Consents, and Authorizations of Domestic Stock Insurers [Repealed]
45-03-02	Insider Trading of Equity Securities of Domestic Stock Insurers [Repealed]
45-03-03	Takeover Bids and Circulation of Material Regarding the Financial Condition of an Insurer
45-03-04	Reporting of Salvage and Subrogation by Fire and Casualty Companies on the Annual Statement [Repealed]
45-03-05	Insurance Holding Company System Model Regulation With Reporting Forms and Instructions
45-03-06	Premium Tax Payments - Estimates
45-03-07	Reinsurance
45-03-07.1	Credit for Reinsurance Model Regulation
45-03-07.2	Life and Health Reinsurance Agreements
45-03-08	Return of Premium
45-03-09	Admission of Foreign Insurance Companies
45-03-10	Unfair Sex Discrimination
45-03-11	Notice, Consent, and Disclosure for Testing of Blood or Other Body Fluids
45-03-12	Investment, Capital, and Surplus Requirements
45-03-13	Regulation of and Standards for Companies Deemed to be in Hazardous Financial Condition
45-03-14	Administrative Supervision Model
45-03-15	Accounting Practices and Procedures
45-03-16	Valuation of Securities and Other Investments [Superseded]
45-03-17	Examinations [Repealed]
45-03-18	Fire District Assignment
45-03-19	Actuarial Opinion and Memorandum Regulation
45-03-19.1	Property and Casualty Actuarial Opinion
45-03-20	Annual Financial Reporting Model Regulation
45-03-21	Demutualization
45-03-22	Mutual Insurance Holding Company Act Rules
45-03-23	Custodial Agreements and the Use of Clearing Corporations
45-03-24	Unclaimed Life Insurance Benefits
<u>45-03-25</u>	<u>Corporate Governance Annual Disclosure Model Regulation</u>

**CHAPTER 45-03-15**

**45-03-15-01. Accounting practices and procedures.**

Every insurance company doing business in this state shall file with the commissioner, pursuant to North Dakota Century Code section 26.1-03-07, the appropriate national association of insurance commissioners annual statement blank, prepared in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the March ~~2015~~2019 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance.

**History:** Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001; March 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; April 1, 2014; January 1, 2016; October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-03-07, 26.1-03-11.1

#### 45-03-15-02. Reporting of financial information.

Every insurance company licensed to do business in this state shall transmit to the commissioner and to the national association of insurance commissioners its most recent financial statements compiled on a quarterly basis, within forty-five days following the calendar quarters ending March thirty-first, June thirtieth, and September thirtieth. The financial statements must be prepared and filed in the form prescribed by the commissioner and in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the March ~~2015~~2019 version of the national association of insurance commissioners accounting practices and procedures manual for property and casualty and life and health insurance. The commissioner may exempt any company or category or class of companies from the filing requirement.

**History:** Effective January 1, 1992; amended effective January 1, 2000; December 1, 2001; March 1, 2004; January 1, 2006; January 1, 2008; April 1, 2010; July 1, 2012; April 1, 2014; January 1, 2016; October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-02-03, 26.1-03-07, 26.1-03-11.1

#### 45-03-15-04. Acceptable media for annual statement filing.

The ~~following media are acceptable to the commissioner for the~~ filing of annual and quarterly statements with the national association of insurance commissioners and every insurance company subject to the requirements of section 45-03-15-03 shall use ~~one of these media~~the national association of insurance commissioners internet filing website in making the filings required by that section:

~~—1.— Diskette; or~~

~~—2.— Electronic transmission of data, including the internet.~~

**History:** Effective December 1, 1998; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-03-07, 26.1-03-11.1

**CHAPTER 45-03-25**  
**CORPORATE GOVERNANCE ANNUAL DISCLOSURE MODEL REGULATION**

Section

<u>45-03-25-01</u>	<u>Authority</u>
<u>45-03-25-02</u>	<u>Purpose</u>
<u>45-03-25-03</u>	<u>Definitions</u>
<u>45-03-25-04</u>	<u>Filing Procedures</u>
<u>45-03-25-05</u>	<u>Contents of Corporate Governance Annual Disclosure</u>
<u>45-03-25-06</u>	<u>Severability Clause</u>

**45-03-25-01. Authority.**

This chapter is adopted pursuant to the authority granted by North Dakota Century Code chapter 26.1-10.3.

**History:** Effective October 1, 2019.  
**General Authority:** NDCC 26.1-10.3  
**Law Implemented:** NDCC 26.1-10.3

**45-03-25-02. Purpose.**

The purpose of this chapter is to set forth the procedures for filing and the required contents of the corporate governance annual disclosure, deemed necessary by the commissioner to carry out the provisions of North Dakota Century Code chapter 26.1-10.3.

**History:** Effective October 1, 2019.  
**General Authority:** NDCC 26.1-10.3  
**Law Implemented:** NDCC 26.1-10.3

**45-03-25-03. Definitions.**

1. "Board" means an insurer's or insurance group's board of directors.
2. "Commissioner" means the North Dakota insurance commissioner.
3. "Insurance group" for the purpose of this chapter means those insurers and affiliates included within an insurance holding company system as defined in North Dakota Century Code section 26.1-10-01.
4. "Insurer" has the same meaning as set forth in North Dakota Century Code section 26.1-29-02, except that it does not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.
5. "Senior management" means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and includes the chief executive officer, chief financial officer, chief operations officer, chief procurement officer, chief legal officer, chief information officer, chief technology officer, chief revenue officer, chief visionary officer, or any other "C" level executive.

**History:** Effective October 1, 2019.  
**General Authority:** NDCC 26.1-10.3  
**Law Implemented:** NDCC 26.1-10.3

#### 45-03-25-04. Filing procedures.

1. An insurer, or the insurance group of which the insurer is a member, required to file a corporate governance annual disclosure pursuant to North Dakota Century Code chapter 26.1-10.3, no later than June first of each calendar year, shall submit to the commissioner a corporate governance annual disclosure that contains the information described in section 45-03-25-05.
2. The corporate governance annual disclosure must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the corporate governance annual disclosure has been provided to the board or the appropriate committee thereof.
3. The insurer or insurance group has discretion regarding the appropriate format for providing the information required by these regulations and may customize the corporate governance annual disclosure to provide the most relevant information necessary to permit the commissioner to gain an understanding of the corporate governance structure, policies, and practices utilized by the insurer or insurance group.
4. For purposes of completing the corporate governance annual disclosure, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level, or both, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the corporate governance annual disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.
5. Notwithstanding subsection 1, and as outlined in North Dakota Century Code section 26.1-10.3-02, if the corporate governance annual disclosure is completed at the insurance group level, it must be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the national association of insurance commissioners. In these instances, a copy of the corporate governance annual disclosure also must be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.
6. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., own risk and solvency assessment summary report, holding company form B or F filings, securities and exchange commission proxy statements, or foreign regulatory reporting requirements) if the documents provide information comparable to the information described in subsection 5. The insurer or insurance group clearly shall reference the location of the relevant information within the corporate governance annual disclosure and attach the referenced document if it is not already filed or available to the regulator.
7. Each year following the initial filing of the corporate governance annual disclosure, the insurer or insurance group shall file an amended version of the previously filed corporate governance annual disclosure indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 26.1-10.3

**Law Implemented:** NDCC 26.1-10.3

**45-03-25-05. Contents of corporate governance annual disclosure.**

1. The insurer or insurance group shall be as descriptive as possible in completing the corporate governance annual disclosure, with inclusion of attachments or example documents used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.
2. The corporate governance annual disclosure must describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following:
  - a. The board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level at which that oversight occurs (e.g., ultimate control level, intermediate holding company, or legal entity). The insurer or insurance group shall describe and discuss the rationale for the current board size and structure; and
  - b. The duties of the board and each of its significant committees and how they are governed (e.g., bylaws, charters, and informal mandates), as well as how the board's leadership is structured, including a discussion of the roles of chief executive officer and chairman of the board within the organization.
3. The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:
  - a. How the qualifications, expertise, and experience of each board member meet the needs of the insurer or insurance group.
  - b. How an appropriate amount of independence is maintained on the board and its significant committees.
  - c. The number of meetings held by the board and its significant committees over the past year as well as information on director attendance.
  - d. How the insurer or insurance group identifies, nominates, and elects members to the board and its committees. The discussion should include, for example:
    - (1) Whether a nomination committee is in place to identify and select individuals for consideration.
    - (2) Whether term limits are placed on directors.
    - (3) How the election and re-election processes function.
    - (4) Whether a board diversity policy is in place and if so, how it functions.
  - e. The processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance, including any board or committee training programs that have been put in place.
4. The insurer or insurance group shall describe the policies and practices for directing senior management, including a description of the following factors:

a. Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience, and integrity to fulfill their prospective roles, including:

(1) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.

(2) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

b. The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(1) Compliance with laws, rules, and regulations; and

(2) Proactive reporting of any illegal or unethical behavior.

c. The insurer's or insurance group's processes for performance evaluation, compensation, and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description must include sufficient detail to allow the commissioner to understand how the organization ensures that compensation programs do not encourage and reward excessive risk taking. Elements to be discussed may include, for example:

(1) The board's role in overseeing management compensation programs and practices.

(2) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(3) How compensation programs are related to both company and individual performance over time;

(4) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(5) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted; and

(6) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

d. The insurer's or insurance group's plans for chief executive officer and senior management succession.

5. The insurer or insurance group shall describe the processes by which the board, its committees, and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

a. How oversight and management responsibilities are delegated between the board, its committees, and senior management;

b. How the board is kept informed of the insurer's strategic plans, the associated risks, and steps that senior management is taking to monitor and manage those risks; and

c. How reporting responsibilities are organized for each critical risk area. The description should allow the commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include, for example, the following critical risk areas of the insurer:

(1) Risk management processes. An own risk and solvency assessment summary report filer may refer to its own risk and solvency assessment summary report pursuant to North Dakota Century Code chapter 26.1-10.2;

(2) Actuarial function;

(3) Investment decisionmaking processes;

(4) Reinsurance decisionmaking processes;

(5) Business strategy/finance decisionmaking processes;

(6) Compliance function;

(7) Financial reporting/internal auditing; and

(8) Market conduct decisionmaking processes.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 26.1-10.3

**Law Implemented:** NDCC 26.1-10.3

**45-03-25-06. Severability clause.**

If any provision of this chapter, or the application of this chapter to any person or circumstance, is held invalid, the validity does not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 26.1-10.3

**Law Implemented:** NDCC 26.1-10.3



## CHAPTER 45-05-09

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

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

~~1.~~ a. One million dollars for primary coverages; and

~~2.~~ b. One hundred thousand dollars for secondary coverages.

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

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

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

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

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

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

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

**History:** Effective April 1, 2015; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-04-02

### 45-05-09-03. Notice required.

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

**History:** Effective April 1, 2015; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-04-02

### 45-05-09-04. Acknowledgment.

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

**History:** Effective April 1, 2015; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-04-02



**ARTICLE 45-06**  
**ACCIDENT AND HEALTH INSURANCE**

Chapter	
45-06-01	Medicare Supplement Insurance Minimum Standards [Superseded]
45-06-01.1	Medicare Supplement Insurance Minimum Standards
45-06-02	Intercarrier Health Insurance Pool
45-06-02.1	Comprehensive Health Association of North Dakota
45-06-03	Standard Health Insurance Proof of Loss Forms [Superseded]
45-06-03.1	Standardized Health Claim Form Model Regulation
45-06-04	Advertising Rules
45-06-05	Long-Term Care Insurance Model Regulation
45-06-05.1	Long-Term Care Insurance Model Regulation
45-06-06	North Dakota Small Employer Health Reinsurance Program [Repealed]
45-06-06.1	Regulation to Implement The Small Employer Health Insurance Availability Act
45-06-07	Model Regulation to Implement Rules Regarding Contracts and Services of Health Maintenance Organizations
45-06-08	Loss Ratios
45-06-09	Group Health Insurance Purchasing Cooperatives
45-06-10	Utilization Review
45-06-11	Regulation on the Crediting of Qualifying Previous Coverage Toward the Reduction of Preexisting Condition Exclusion Periods
45-06-12	Regulation to Implement North Dakota Century Code Chapter 26.1-36.4, Relating to Hospital and Medical Insurance
45-06-13	Provider-Sponsored Organizations
45-06-14	Multiple Employer Welfare Arrangements
45-06-15	Short-Term Care Insurance
<u>45-06-16</u>	<u>Short-Term Limited-Duration Insurance</u>

**CHAPTER 45-06-01.1**  
**MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS**

Section	
45-06-01.1-01	Applicability and Scope
45-06-01.1-02	Definitions
45-06-01.1-03	Policy Definitions and Terms
45-06-01.1-04	Policy Provisions
45-06-01.1-05	Minimum Benefit Standards for Prestandardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to January 1, 1992
45-06-01.1-06	Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After January 1, 1992, and With an Effective Date for Coverage Prior to June 1, 2010
45-06-01.1-06.1	Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery With an Effective Date for Coverage on or After June 1, 2010
45-06-01.1-07	Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After January 1, 1992, and With an Effective Date for Coverage Prior to June 1, 2010
45-06-01.1-07.1	Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery With an Effective Date for Coverage on or After June 1, 2010
<u>45-06-01.1-07.2</u>	<u>Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020</u>

- 45-06-01.1-08 Medicare Select Policies and Certificates
- 45-06-01.1-09 Open Enrollment
- 45-06-01.1-09.1 Guaranteed Issue for Eligible Persons
- 45-06-01.1-10 Standards for Claims Payment
- 45-06-01.1-11 Loss Ratio Standards and Refund or Credit of Premium
- 45-06-01.1-12 Filing and Approval of Policies and Certificates and Premium Rates
- 45-06-01.1-13 Permitted Compensation Arrangements
- 45-06-01.1-14 Required Disclosure Provisions
- 45-06-01.1-15 Requirements for Application Forms and Replacement Coverage
- 45-06-01.1-16 Filing Requirements for Advertising
- 45-06-01.1-17 Standards for Marketing
- 45-06-01.1-18 Appropriateness of Recommended Purchase and Excessive Insurance
- 45-06-01.1-19 Reporting of Multiple Policies
- 45-06-01.1-20 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probationary Periods in Replacement Policies or Certificates
- 45-06-01.1-20.1 Prohibition Against Use of Genetic Information and Requests for Genetic Testing
- 45-06-01.1-21 Separability
- 45-06-01.1-22 Effective Date [\[Repealed\]](#)

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

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

1. General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter:
  - a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.
  - b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
  - c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.
  - d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
  - e. Each Medicare supplement policy shall be guaranteed renewable.

- (1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.
  - (2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
  - (3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5, the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:
    - (a) Provides for continuation of the benefits contained in the group policy; or
    - (b) Provides for benefits that otherwise meet the requirements of this subsection.
  - (4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group the issuer shall:
    - (a) Offer the certificate holder the conversion opportunity described in paragraph 3; or
    - (b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
  - (5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare part D benefits will not be considered in determining a continuous loss.
- g. (1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period not to exceed twenty-four months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medical assistance eligibility subject to adjustment for paid claims.
- (2) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.
  - (3) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal

regulation at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

- (4) Reinstitution of coverages as described in paragraphs 2 and 3:
  - (a) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
  - (b) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and
  - (c) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.
2. Standards for basic benefits common to Medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package but not in lieu of it.
  - a. Coverage of part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;
  - b. Coverage of part A Medicare-eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
  - c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days coverage of one hundred percent of the Medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
  - d. Coverage under Medicare parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, unless replaced in accordance with federal regulations;
  - e. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare-eligible expenses under part B regardless of hospital confinement, subject to the Medicare part B deductible; and
  - f. Hospice care. Coverage of cost-sharing for all part A Medicare eligible hospice care and respite care expenses.

3. Standards for additional benefits. The following additional benefits shall be included in Medicare supplement benefit plans B, C, D, F, F with high deductible, G, M, and N as provided by section 45-06-01.1-07.1.
  - a. Medicare part A deductible. Coverage for one hundred percent of the Medicare part A inpatient hospital deductible amount per benefit period.
  - b. Medicare part A deductible. Coverage for fifty percent of the Medicare part A inpatient hospital deductible amount per benefit period.
  - c. Skilled nursing facility care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare part A.
  - d. Medicare part B deductible. Coverage for one hundred percent of the Medicare part B deductible amount per calendar year regardless of hospital confinement.
  - e. One hundred percent of the Medicare part B excess charges. Coverage for all of the difference between the actual Medicare part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved part B charge.
  - f. Medically necessary emergency care in a foreign country. Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

**History:** Effective July 1, 2009; [amended effective October 1, 2019.](#)

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

**Law Implemented:** NDCC 26.1-36.1-02

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

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

1.
  - a. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic benefits, as defined in subsection 2 of section 45-06-01.1-06.1.
  - b. If an issuer makes available any of the additional benefits described in subsection 3 of section 45-06-01.1-06.1, or offers standardized benefit plans K or L as described in subdivisions h and i of subsection 5, then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic benefits as described in subdivision a, a policy form or certificate

form containing either standardized benefit plan C as described in subdivision c of subsection 5 or standardized benefit plan F as described in subdivision e of subsection 5.

2. No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subsection 6 and section 45-06-01.1-08.
3. Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in this subsection and conform to the definitions in section 45-06-01.1-02. Each benefit shall be structured in accordance with the format provided in subsections 2 and 3 of section 45-06-01.1-06.1; or, in the case of plans K or L, in subdivisions h and i of subsection 5 and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.
4. In addition to the benefit plan designations required in subsection 3, an issuer may use other designations to the extent permitted by law.
5. Makeup of 2010 standardized benefit plans:
  - a. Standardized Medicare supplement benefit plan A shall include only the following: the basic benefits as defined in subsection 2 of section 45-06-01.1-06.1.
  - b. Standardized Medicare supplement benefit plan B shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the Medicare part A deductible as defined in subdivision a of subsection 3 of section 45-06-01.1-06.1.
  - c. Standardized Medicare supplement benefit plan C shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, one hundred percent of the Medicare part B deductible, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, and f of subsection 3 of section 45-06-01.1-06.1, respectively.
  - d. Standardized Medicare supplement benefit plan D shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, and f of subsection 3 of section 45-06-01.1-06.1, respectively.
  - e. Standardized Medicare supplement plan F shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the Medicare part A deductible, the skilled nursing facility care, one hundred percent of the Medicare part B deductible, one hundred percent of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively.
  - f. Standardized Medicare supplement plan F with high deductible shall include only the following: one hundred percent of covered expenses following the payment of the annual deductible set forth in paragraph 2.
    - (1) The basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, one hundred percent of the Medicare part B deductible, one hundred percent of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, d, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively.

- (2) The annual deductible in plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars and shall be adjusted annually from 1999 by the secretary of the United States department of health and human services to reflect the change in the consumer price index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.
- g. Standardized Medicare supplement benefit plan G shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, one hundred percent of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, e, and f of subsection 3 of section 45-06-01.1-06.1, respectively. Effective January 1, 2020, the standardized benefit plans described in subdivision d of subsection 1 of section 45-06-01.1-07.2 of this regulation (Redesignated plan G high deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2010.
- h. Standardized Medicare supplement plan K is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall include only the following:
- (1) Part A hospital coinsurance, sixty-first through ninetieth days. Coverage of one hundred percent of the part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;
  - (2) Part A hospital coinsurance, ninety-first through one hundred fiftieth days. Coverage of one hundred percent of the part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;
  - (3) Part A hospitalization after one hundred fifty days. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Medicare part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
  - (4) Medicare part A deductible. Coverage for fifty percent of the Medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph 10;
  - (5) Skilled nursing facility care. Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare part A until the out-of-pocket limitation is met as described in paragraph 10;
  - (6) Hospice care. Coverage for fifty percent of cost-sharing for all part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph 10;
  - (7) Blood. Coverage for fifty percent, under Medicare part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as



defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in paragraph 10;

- (8) Part B cost-sharing. Except for coverage provided in paragraph 9, coverage for fifty percent of the cost-sharing otherwise applicable under Medicare part B after the policyholder pays the part B deductible until the out-of-pocket limitation is met as described in paragraph 10;
  - (9) Part B preventive services. Coverage of one hundred percent of the cost-sharing for Medicare part B preventive services after the policyholder pays the part B deductible; and
  - (10) Cost-sharing after out-of-pocket limits. Coverage of one hundred percent of all cost-sharing under Medicare parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States department of health and human services.
- i. Standardized Medicare supplement plan L is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall include only the following:
    - (1) The benefits described in paragraphs 1, 2, 3, and 9 of subdivision h of subsection 5 of section 45-06-01.1-07.1;
    - (2) The benefit described in paragraphs 4, 5, 6, 7, and 8 of subdivision h of subsection 5 of section 45-06-01.1-07.1, but substituting seventy-five percent for fifty percent; and
    - (3) The benefit described in paragraph 10 of subdivision h of subsection 5 of section 45-06-01.1-07.1, but substituting two thousand dollars for four thousand dollars.
  - j. Standardized Medicare supplement plan M shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus fifty percent of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subdivisions b, c, and f of subsection 3 of section 45-06-01.1-06.1, respectively.
  - k. Standardized Medicare supplement plan N shall include only the following: the basic benefit as defined in subsection 2 of section 45-06-01.1-06.1, plus one hundred percent of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subdivisions a, c, and f of subsection 3 of section 45-06-01.1-06.1, respectively, with copayments in the following amounts:
    - (1) The lesser of twenty dollars or the Medicare part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and
    - (2) The lesser of fifty dollars or the Medicare part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare part A expense.
6. New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare



supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

**History:** Effective July 1, 2009; amended effective October 1, 2019.

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

**Law Implemented:** NDCC 26.1-36.1-02

**45-06-01.1-07.2. Standard Medicare supplement benefit plans for 2020 standardized Medicare supplement benefit plan policies or certificates issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020.**

The Medicare Access and CHIP Reauthorization Act of 2015 requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of sections 45-06-01.1-06, 45-06-01.1-06.1, 45-06-01.1-07, and 45-06-01.1-07.1.

1. Benefit requirements. The standards and requirements of section 45-06-01.1-07.1 apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:
  - a. Standardized Medicare supplement benefit plan C is redesignated as plan D and must provide the benefits contained in subdivision c of subsection 5 of section 45-06-01.1-07.1 of this regulation but may not provide coverage for one hundred percent or any portion of the Medicare part B deductible.
  - b. Standardized Medicare supplement benefit plan F is redesignated as plan G and must provide the benefits contained in subdivision e of subsection 5 of section 45-06-01.1-07.1 of this regulation but may not provide coverage for one hundred percent or any portion of the Medicare part B deductible.
  - c. Standardized Medicare supplement benefit plans C, F, and F with high deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.
  - d. Standardized Medicare supplement benefit plan F with high deductible is redesignated as plan G with high deductible and must provide the benefits contained in subdivision f of subsection 5 of section 45-06-01.1-07.1 of this regulation but may not provide coverage for one hundred percent or any portion of the Medicare part B deductible; provided further that, the Medicare part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.
  - e. The reference to plans C or F contained in subdivision b of subsection 1 of section 45-06-01.1-07.1 is deemed a reference to plans D or G for purposes of this section.
2. Applicability to certain individuals. This section applies to only individuals newly eligible for Medicare on or after January 1, 2020:
  - a. By reason of attaining age sixty-five on or after January 1, 2020; or

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

3. Guaranteed issue for eligible persons. For purposes of subsection 5 of section 45-06-01.1-09.1 in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F with high deductible) is deemed to be a reference to Medicare supplement policy D or G (including G with high deductible), respectively, that meet the requirements of subsection 1.

4. Applicability to waived states. In the case of a state described in section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) Medicare Access and CHIP Reauthorization Act of 2015 prohibits the coverage of the Medicare part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

5. Offer of redesignated plans to individuals other than newly eligible. On or after January 1, 2020, the standardized benefit plans described in subdivision d of subsection 1 may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in subsection 5 of section 45-06-01.1-07.1 of this regulation.

**History:** Effective January 1, 2020.

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

**Law Implemented:** NDCC 26.1-36.1-02

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

##### **1. General rules.**

- a. Medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of the provision must be consistent with the type of contract issued. Such provision must be appropriately captioned and must appear on the first page of the policy, and must include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.
- b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge must be set forth in the policy.
- c. Medicare supplement policies or certificates may not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.
- d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "preexisting condition limitations".

- e. Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
- f. (1) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare must provide to those applicants a guide to health insurance for people with Medicare in the form developed jointly by the national association of insurance commissioners and the centers for Medicare and Medicaid services and in a type size no smaller than twelve-point type. Delivery of the guide must be made whether or not such policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the guide must be made to the applicant at the time of application and acknowledgment of receipt of the guide must be obtained by the insurer. Direct response issuers must deliver the guide to the applicant upon request but not later than at the time the policy is delivered.
- (2) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

**2. Notice requirements.**

- a. As soon as practicable, but no later than thirty days prior to the annual effective date of any Medicare benefit changes, an issuer must notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice must:
  - (1) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and
  - (2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.
- b. The notice of benefit modifications and any premium adjustments must be in outline form and in clear and simple terms so as to facilitate comprehension.
- c. Such notices may not contain or be accompanied by any solicitation.

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

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

- a. Issuers must provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, must obtain an acknowledgment of receipt of the outline from the applicant; and
- b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve-point type, immediately above the company name:

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

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

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

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

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

### Basic Benefits:

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

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
<p>*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year <del>[\$2,000]</del>[\$2,240] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed <del>[\$2,000]</del>[\$2,240]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.</p>							Out-of-pocket limit <del>[\$4,620]</del> [\$5,240]; paid at 100% after limit reached	Out-of-pocket limit <del>[\$2,310]</del> [\$2,620]; paid at 100% after limit reached		

**PREMIUM INFORMATION** [Boldface Type]

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

**DISCLOSURES** [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

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

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

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

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

**POLICY REPLACEMENT** [Boldface Type]

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

**NOTICE** [Boldface Type]

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

[for agents:]

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

[for direct response:]

[insert company's name] is not connected with Medicare.

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

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

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

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

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

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

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

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

Note: A ✓ means one hundred percent of the benefits is paid.

Benefits	Plans Available to All Applicants								Medicare Eligible 2020 Only	First Before 2020 Only
	A	B	D	G <sup>1</sup>	K	L	M	N	C	F <sup>1</sup>
Medicare part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment					50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance					50%	75%	✓	✓	✓	✓
Medicare part A deductible					50%	75%	50%	✓	✓	✓
Medicare part B deductible									✓	✓
Medicare part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2018] <sup>2</sup>					[\$5,240] <sup>2</sup>	[\$2,620] <sup>2</sup>				

<sup>1</sup>Plans F and G also have a high deductible option which require first paying a plan deductible of [\$2,240] before the plan begins to pay. Once the plan deductible is met, the plan pays one hundred percent of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare part B deductible toward meeting the plan deductible.

<sup>2</sup>Plans K and L pay one hundred percent of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.



<sup>3</sup>Plan N pays one hundred percent of the part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

**PLAN A**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the additional 365 days	All but <del>[\$1,068]</del> [\$1,340] All but <del>[\$267]</del> [\$335] a day All but <del>[\$534]</del> [\$670] a day \$0 \$0	\$0 <del>[\$267]</del> [\$335] a day <del>[\$534]</del> [\$670] a day 100% of Medicare-eligible expenses \$0	<del>[\$1,068]</del> [\$1,340] (Part A deductible) \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but <del>[\$133.50]</del> [\$167.50] a day \$0	\$0 \$0 \$0	\$0 Up to <del>[\$133.50]</del> [\$167.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of	All but very limited copayment/coinsurance for outpatient drugs and	Medicare copayment/coinsurance	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
terminal illness.	inpatient respite care		

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

**PLAN A**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B Excess Charges (Above Medicare-approved amounts)	\$0  Generally 80%  \$0	\$0  Generally 20%  \$0	<del>[\$135]</del> [\$183] (Part B deductible)  \$0  All costs
<b>BLOOD</b> First 3 pints Next <del>[\$135]</del> [\$183] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 <del>[\$135]</del> [\$183] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

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

**PLAN B**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>[\$1,068]</del> [\$1,340]	<del>[\$1,068]</del> [\$1,340] (Part A deductible)	\$0
61st thru 90th day	All but <del>[\$267]</del> [\$335] a day	<del>[\$267]</del> [\$335] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but <del>[\$534]</del> [\$670] a day	<del>[\$534]</del> [\$670] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
--Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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 <del>[\$133.50]</del> [\$167.50] a day	\$0	Up to <del>[\$133.50]</del> [\$167.50] a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

**PLAN B**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B Excess Charges (Above Medicare-approved amounts)	\$0  Generally 80%  \$0	\$0  Generally 20%  \$0	<del>[\$135]</del> [\$183] (Part B deductible)  \$0  All costs
<b>BLOOD</b> First 3 pints Next <del>[\$135]</del> [\$183] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 <del>[\$135]</del> [\$183] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

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

**PLAN C**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>[\$1,068]</del> [\$1,340]	<del>[\$1,068]</del> [\$1,340] (Part A deductible)	\$0
61st thru 90th day	All but <del>[\$267]</del> [\$335] a day	<del>[\$267]</del> [\$335] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but <del>[\$534]</del> [\$670] a day	<del>[\$534]</del> [\$670] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
--Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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 <del>[\$133.50]</del> [\$167.50] a day	Up to <del>[\$133.50]</del> [\$167.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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



**PLAN C**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts*	\$0	<del>[\$135]</del> [\$183] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next <del>[\$135]</del> [\$183] of Medicare-approved amounts*	\$0	<del>[\$135]</del> [\$183] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b>			
MEDICARE-APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First <del>[\$135]</del> [\$183] of Medicare-approved amounts*	\$0	<del>[\$135]</del> [\$183] (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

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

**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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>[\$1,068]</del> [\$1,340]	<del>[\$1,068]</del> [\$1,340] (Part A deductible)	\$0
61st thru 90th day	All but <del>[\$267]</del> [\$335] a day	<del>[\$267]</del> [\$335] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but <del>[\$534]</del> [\$670] a day	<del>[\$534]</del> [\$670] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
--Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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 <del>[\$133.50]</del> [\$167.50] a day	Up to <del>[\$133.50]</del> [\$167.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

**PLAN D**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts*	\$0	\$0	<del>[\$135]</del> [\$183] (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next <del>[\$135]</del> [\$183] of Medicare-approved amounts*	\$0	\$0	<del>[\$135]</del> [\$183] (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN D**

**PARTS A & B**

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

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

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

**PLAN F or HIGH DEDUCTIBLE PLAN F**

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

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY <del>[\$2,000]</del> [\$2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO <del>[\$2,000]</del> [\$2,240] DEDUCTIBLE,**] YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>[\$1,068]</del> [\$1,340]	<del>[\$1,068]</del> [\$1,340] (Part A deductible)	\$0
61st thru 90th day	All but <del>[\$267]</del> [\$335] a day	<del>[\$267]</del> [\$335] a day	\$0
91st day and after:			
While using 60 lifetime reserve days	All but <del>[\$534]</del> [\$670] a day	<del>[\$534]</del> [\$670] a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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 <del>[\$133.50]</del> [\$167.50] a day	Up to <del>[\$133.50]</del> [\$167.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/ coinsurance for outpatient drugs and	Medicare copayment/ coinsurance	\$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [ <del>\$2,000</del> ] <u>\$2,240</u> DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO [ <del>\$2,000</del> ] <u>\$2,240</u> DEDUCTIBLE,**] YOU PAY
	inpatient respite care		

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



**PLAN F or HIGH DEDUCTIBLE PLAN F**

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

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY <del>[\$2,000]</del> [\$2,240] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO <del>[\$2,000]</del> [\$2,240] DEDUCTIBLE,**] YOU PAY
<b>MEDICAL EXPENSES -</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts*  Remainder of Medicare-approved amounts  Part B Excess Charges (Above Medicare-approved amounts)	\$0  Generally 80%  \$0	<del>[\$135]</del> [\$183] (Part B deductible)  Generally 20%  100%	\$0  \$0  \$0
<b>BLOOD</b> First 3 pints Next <del>[\$135]</del> [\$183] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs <del>[\$135]</del> [\$183] (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN F or HIGH DEDUCTIBLE PLAN F**

**PARTS A & B**

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

**OTHER BENEFITS -- NOT COVERED BY MEDICARE**

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

**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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$1,068]	[\$1,068] (Part A deductible)	\$0
61st thru 90th day	All but [\$267] a day	[\$267] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but [\$534] a day	[\$534] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
--Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$133.50] a day	Up to [\$133.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

**PLAN G**

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

~~\* Once you have been billed [\$133.50] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. OTHER BENEFITS -- NOT COVERED BY MEDICARE~~

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

**PLAN G**  
**PARTS A & B**

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

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL--NOT COVERED BY MEDICARE</b>			
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 or HIGH DEDUCTIBLE PLAN G**

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

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$2,240] DEDUCTIBLE, **] PLAN PAYS</b>	<b>[IN ADDITION TO [\$2,240] DEDUCTIBLE, **] YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used: --Additional 365 days --Beyond the additional 365 days	All but [\$1,340] All but [\$335] a day All but [\$670] a day \$0 \$0	[\$1,340] (Part A deductible) [\$335] a day [\$670] a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$167.50] a day \$0	\$0 Up to [\$167.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G or HIGH DEDUCIBLE PLAN G**

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

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$2,240] DEDUCTIBLE, **] PLAN PAYS</b>	<b>[IN ADDITION TO [\$2,240] DEDUCTIBLE, **] YOU PAY</b>
<b><u>MEDICAL EXPENSES -</u></b> <u>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</u>			
<u>First [\$183] of Medicare-approved amounts*</u>	\$0	\$0	[\$183] (Part B deductible)
<u>Remainder of Medicare-approved amounts</u>	Generally 80%	Generally 20%	\$0
<u>Part B Excess Charges (Above Medicare-approved amounts)</u>	\$0	100%	\$0
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	\$0	All costs	\$0
<u>Next [\$183] of Medicare-approved amounts*</u>	\$0	\$0	[\$183] (unless Part B deductible has been met)
<u>Remainder of Medicare-approved amounts</u>	80%	20%	\$0
<b><u>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</u></b>	100%	\$0	\$0



**PLAN G or HIGH DEDUCTIBLE PLAN G**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$2,240] DEDUCTIBLE, **] PLAN PAYS</b>	<b>[IN ADDITION TO [\$2,240] DEDUCTIBLE, **] YOU PAY</b>
<b>HOME HEALTH CARE</b>			
<u>MEDICARE-APPROVED SERVICES</u>			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First [\$183] of Medicare-approved amounts*	\$0	\$0	[\$183] (unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	\$0

**PLAN G or HIGH DEDUCTIBLE PLAN G**

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

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

## PLAN K

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>[\$1,068]</del> [\$1,340]	<del>[\$534]</del> [\$670] (50% of Part A deductible)	<del>[\$534]</del> [\$670] (50% of Part A deductible)♦
61st thru 90th day	All but <del>[\$267]</del> [\$335] a day	<del>[\$267]</del> [\$335] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but <del>[\$534]</del> [\$670] a day		
--Once lifetime reserve days are used:		<del>[\$534]</del> [\$670] a day	\$0
--Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
--Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE**</b>			
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 <del>[\$133.50]</del> [\$167.50] a day	Up to <del>[\$66.75]</del> [\$83.75] a day	Up to <del>[\$166.75]</del> [\$183.75] a day♦
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	50%	50%♦
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
	inpatient respite care		

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

**PLAN K**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES--</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts****  Preventive benefits for Medicare-covered services  Remainder of Medicare-approved amounts	\$0  Generally 75% or more of Medicare-approved amounts  Generally 80%	\$0  Remainder of Medicare-approved amounts  Generally 10%	<del>[\$135]</del> [\$183] (Part B deductible)****◆  All costs above Medicare-approved amounts  Generally 10%◆
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of <del>[\$4,620]</del> [\$5,240])*
<b>BLOOD</b> First 3 pints Next <del>[\$135]</del> [\$183] of Medicare-approved amounts**** Remainder of Medicare-approved amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%◆ <del>[\$135]</del> [\$183] (Part B deductible)****◆ Generally 10%◆
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

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

**PLAN K**  
**PARTS A & B**

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

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

**PLAN L**

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>[\$1,068]</del> [\$1,340]	<del>[\$808.50]</del> [\$1,005] (75% of Part A deductible)	<del>[\$267]</del> [\$335] (25% of Part A deductible)♦
61st thru 90th day	All but <del>[\$267]</del> [\$335] a day	<del>[\$267]</del> [\$335] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but <del>[\$534]</del> [\$670] a day	<del>[\$534]</del> [\$670] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
--Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE**</b>			
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 <del>[\$133.50]</del> [\$167.50] a day	Up to <del>[\$100.13]</del> [\$125.63] a day	Up to <del>[\$33.38]</del> [\$41.88] a day♦
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	75%	25%♦
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and	75% of copayment/coinsurance	25% of copayment/coinsurance♦

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
	inpatient respite care		

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

**PLAN L**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES--</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts****  Preventive benefits for Medicare-covered services  Remainder of Medicare-approved amounts	\$0  Generally 75% or more of Medicare-approved amounts  Generally 80%	\$0  Remainder of Medicare-approved amounts  Generally 15%	<del>[\$135]</del> [\$183] (Part B deductible)****♦  All costs above Medicare-approved amounts  Generally 5%♦
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of <del>[\$2,310]</del> [\$2,620])*
<b>BLOOD</b>  First 3 pints  Next <del>[\$135]</del> [\$183] of Medicare-approved amounts****  Remainder of Medicare-approved amounts	\$0  \$0  Generally 80%	75%  \$0  Generally 15%	25%♦  <del>[\$135]</del> [\$183] (Part B deductible)♦  Generally 5%♦
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to ~~[\$2,310]~~[\$2,620] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**



**PLAN L**  
**PARTS A & B**

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

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

**PLAN M**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>[\$1,068]</del> [\$1,340]	<del>[\$534]</del> [\$670] (50% of Part A deductible)	<del>[\$534]</del> [\$670] (50% of Part A deductible)
61st thru 90th day	All but <del>[\$267]</del> [\$335] a day	<del>[\$267]</del> [\$335] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but <del>[\$534]</del> [\$670] a day	<del>[\$534]</del> [\$670] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
--Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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 <del>[\$133.50]</del> [\$167.50] a day	Up to <del>[\$133.50]</del> [\$167.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN M**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts*  Remainder of Medicare-approved amounts	\$0  Generally 80%	\$0  Generally 20%	<del>[\$135]</del> [\$183] (Part B deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>  First 3 pints  Next <del>[\$135]</del> [\$183] of Medicare-approved amounts*  Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 <del>[\$135]</del> [\$183] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN M**  
**PARTS A & B**

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

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

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

**PLAN N**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but <del>[\$1,068]</del> [\$1,340]	<del>[\$1,068]</del> [\$1,340] (Part A deductible)	\$0
61st thru 90th day	All but <del>[\$267]</del> [\$335] a day	<del>[\$267]</del> [\$335] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but <del>[\$534]</del> [\$670] a day	<del>[\$534]</del> [\$670] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
--Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
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 <del>[\$133.50]</del> [\$167.50] a day	Up to <del>[\$133.50]</del> [\$167.50] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	0%

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

billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN N**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES--</b> 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 <del>[\$135]</del> [\$183] of Medicare-approved amounts*  Remainder of Medicare-approved amounts	\$0  Generally 80%	\$0  Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	<del>[\$135]</del> [\$183] (Part B deductible)  Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next <del>[\$135]</del> [\$183] of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 <del>[\$135]</del> [\$183] (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0



**PLAN N**  
**PARTS A & B**

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

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

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

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

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

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

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

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

**General Authority:** NDCC 26.1-36.1-03, 26.1-36.1-05

**Law Implemented:** NDCC 26.1-36.1-05

**45-06-01.1-22. Effective date.**

Repealed effective October 1, 2019.

~~—This chapter is effective on September 1, 2005. Insurers are permitted to continue using current forms, or to make changes to current forms if offering plan K or L, as appropriate through 2005. Insurers may offer any authorized plan upon approval by the commissioner.~~

~~**History:** Effective September 1, 2005.~~

~~**General Authority:** NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03~~

~~**Law Implemented:** NDCC 26.1-36.1~~

## CHAPTER 45-06-05.1 LONG-TERM CARE INSURANCE MODEL REGULATION

### Section

45-06-05.1-01	Applicability and Scope
45-06-05.1-02	Definitions
45-06-05.1-03	Policy Definitions
45-06-05.1-04	Policy Practices and Provisions
45-06-05.1-05	Unintentional Lapse
45-06-05.1-06	Required Disclosure Provisions
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<a href="#">45-06-05.1-08.1</a>	<a href="#">Initial Filing Requirements for Policies Issued After October 1, 2019</a>
45-06-05.1-09	Prohibition Against Post-Claims Underwriting
45-06-05.1-10	Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies
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45-06-05.1-12	Requirements for Application Forms and Replacement Coverage
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45-06-05.1-24	Nonforfeiture Benefit Requirement
45-06-05.1-25	Standards for Benefit Triggers
45-06-05.1-26	Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts
45-06-05.1-27	Standard Format Outline of Coverage
45-06-05.1-28	Requirement to Deliver Shopper's Guide
45-06-05.1-29	Penalties

### **45-06-05.1-01. Applicability and scope.**

Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after March 1, 2004, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations, and all similar organizations. Certain provisions of this chapter apply only to qualified long-term care insurance contracts as noted. Policies delivered or issued for delivery in this state before March 1, 2004, are governed by chapter 45-06-05.

Additionally, this chapter is intended to apply to policies having indemnity benefits triggered by activities of daily living and sold as disability income insurance, if:

1. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

2. The disability income policy is advertised, marketed, or offered as insurance for long-term care services; or

3. Benefits under the policy may commence after the policyholder has reached social security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

**History:** Effective March 1, 2004; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

#### **45-06-05.1-03. Policy definitions.**

No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

1. "Activities of daily living" means at least bathing, continence, dressing, eating, toileting, and transferring.
2. "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.
3. "Adult day care" means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.
4. "Bathing" means washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
5. "Cognitive impairment" means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.
6. "Continence" means the ability to maintain control of bowel and bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for catheter or colostomy bag.
7. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
8. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table or by a feeding tube or intravenously.
9. "Hands-on assistance" means physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.
10. "Home health care services" means medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.
11. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended" or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and

popularly known as The Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

12. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
13. "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.
14. "Skilled nursing care", "~~intermediate care~~", "personal care", "home care", "specialized care", "assisted living care", and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.
15. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
16. "Transferring" means moving into or out of a bed, chair, or wheelchair.
17. All providers of services, including "skilled nursing facility", "extended care facility", "~~intermediate care facility~~", "convalescent nursing home", "personal care facility", "specialized care providers", "assisted living facility", and "home care agency", shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration, or degree status of those providing or supervising the services. ~~The~~When the definition may require that requires the provider be appropriately licensed ~~or~~ certified, or registered, it also must state what requirements a provider must meet in lieu of licensure, certification, or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified, or registered, or when the state licenses, certifies, or registers the provider of services under another name.

**History:** Effective March 1, 2004; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

#### **45-06-05.1-04. Policy practices and provisions.**

1. **Renewability.** The terms "guaranteed renewable" and "noncancelable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of section 45-06-05.1-06.
  - a. A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancelable".
  - b. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.
  - c. The term "noncancelable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.
  - d. The term "level premium" may only be used when the insurer does not have the right to change the premium.

e. In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

2. **Limitations and exclusions.** A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

a. Preexisting conditions or diseases~~;~~

b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of alzheimer's disease~~;~~

c. Alcoholism and drug addiction~~;~~

d. Illness, treatment, or medical condition arising out of:

(1) War or act of war (whether declared or undeclared);

(2) Participation in a felony, riot, or insurrection;

(3) Service in the armed forces or units auxiliary thereto;

(4) Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

(5) Aviation (this exclusion applies only to non-fare-paying passengers).

e. Treatment provided in a government facility, unless otherwise required by law, services for which benefits are available under Medicare or other governmental program, except Medicaid, any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance~~;~~

f. ~~Expenses for services or items available or paid under another long-term care insurance or health insurance policy;~~

~~g.~~ In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount~~;~~ ~~and.~~

~~h.g.~~ (1) This subsection is not intended to prohibit exclusions and limitations by type of provider ~~or.~~ However, a long-term care issuer may not deny a claim because services are provided in a state other than the state of policy issued under the following conditions:

(a) When the state other than the state of policy issue does not have the provider licensing, certification, or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification, or registration; or

(b) When the state other than the state of policy issue licenses, certifies, or registers the provider under another name.

(2) For purposes of this subdivision, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

h. This subsection is not intended to prohibit territorial limitations.

3. **Extension of benefits.** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.
4. **Continuation or conversion.**
  - a. Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.
  - b. For the purposes of this section, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels, and administrative complexity.
  - c. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and any group policy which it replaced, for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.
  - d. For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. When the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels, and administrative complexity.
  - e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.
  - f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. When the group policy from which conversion is made replaced previous group



coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

- g. Continuation of coverage or issuance of a converted policy shall be mandatory, except when:
    - (1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
    - (2) The terminating coverage is replaced not later than thirty-one days after termination, by group coverage effective on the day following the termination of coverage:
      - (a) Providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and
      - (b) The premium for which is calculated in a manner consistent with the requirements of subdivision f.
  - h. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.
  - i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.
  - j. Notwithstanding any other provision of this section, an insured individual whose eligibility for group long-term care coverage is based upon the insured individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.
  - k. For the purposes of this section, a "managed care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.
5. **Discontinuance and replacement.** If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:
- a. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
  - b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.
6. a. The premium charged to an insured shall not increase due to either:
- (1) The increasing age of the insured at ages beyond sixty-five; or



- (2) The duration the insured has been covered under the policy.
- b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under section 45-06-05.1-24, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.
- c. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under section 45-06-05.1-24, the initial annual premium shall be based on the reduced benefits.

**7. Electronic enrollment for group policies.**

- a. In the case of a group defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:
  - (1) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;
  - (2) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and
  - (3) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of nonpublic personal financial information and nonpublic personal health information as defined by ~~article 45-14~~[chapter 45-14-01](#) is maintained.
- b. The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

**History:** Effective March 1, 2004; [amended effective October 1, 2019](#).

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

**45-06-05.1-07. Required disclosure of rating practices to consumers.**

- 1. This section shall apply as follows:
  - a. Except as provided in subdivision b, this section applies to any long-term care policy or certificate issued in this state on or after September 1, 2004.
  - b. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following March 1, 2005.
- 2. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subsection to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this section to the applicant no later than at the time of delivery of the policy or certificate.
  - a. A statement that the policy may be subject to rate increases in the future;

- b. An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;
  - c. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;
  - d. A general explanation for applying premium rate or rate schedule adjustments that shall include:
    - (1) A description of when premium rate or rate schedule adjustments will be effective, e.g., next anniversary date, next billing date, etc.; and
    - (2) The right to a revised premium rate or rate schedule as provided in subdivision c if the premium rate or rate schedule is changed; and
  - e. (1) Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state that, at a minimum, identifies:
    - (a) The policy forms for which premium rates have been increased;
    - (b) The calendar years when the form was available for purchase; and
    - (c) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.
  - (2) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.
  - (3) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.
  - (4) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this section or the end of a twenty-four-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with paragraph 1.
  - (5) If the acquiring insurer in paragraph 4 files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in paragraph 4, the acquiring insurer shall make all disclosures required by this subdivision, including disclosure of the earlier rate increase referenced in paragraph 4.
3. An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under subdivisions a through e of subsection 2. If due to the method of application the applicant cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

4. An insurer shall use the forms in appendices B and F to comply with the requirements of subsections 2 and 3.
5. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection 2 when the rate increase is implemented.

**History:** Effective March 1, 2004; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

#### **45-06-05.1-08. Initial filing requirements.**

1. This section applies to any long-term care policy issued in this state on or after September 1, 2004.
2. An insurer shall provide the information listed in this subsection to the commissioner ~~thirty~~sixty days prior to making a long-term care insurance form available for sale.
  - a. A copy of the disclosure documents required in section 45-06-05.1-07; and
  - b. An actuarial certification consisting of at least the following:
    - (1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
    - (2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
    - (3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
    - (4) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
      - (a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
      - (b) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
      - (c) A statement that the net valuation premium for renewal years does not increase, except for attained-age rating where permitted; and
      - (d) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations in which this does not occur:
        - [1] An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; and

- [2] If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subsection 3 based on a standard age distribution; and
- (5) (a) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
  - (b) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.
3. a. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.
  - b. In the event the commissioner asks for additional information under this provision, the period in subsection 2 does not include the period during which the insurer is preparing the requested information.

**History:** Effective March 1, 2004; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

**45-06-05.1-08.1. Initial filing requirements for policies issued after October 1, 2019.**

1. This section applies to any long-term care policy issued in this state on or after March 1, 2020.
2. An insurer shall provide the information listed in this subsection to the commissioner sixty days prior to making a long-term care insurance form available for sale.
  - a. A copy of the disclosure documents required in section 45-06-05.1-07.
  - b. An actuarial certification consisting of at least the following:
    - (1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated.
    - (2) A statement that the policy design and coverage provided have been reviewed and taken into consideration.
    - (3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration.
    - (4) A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in subparagraphs a and b:
      - (a) A composite margin may not be less than ten percent of lifetime claims.
      - (b) A greater margin may be appropriate in circumstances where the company has less credible experience to support its assumptions used to determine the premium rates.
    - (5) (a) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(b) A comparison of the premium schedules for similar policy forms currently available from the insurer with an explanation of the differences.

(6) A statement that reserve requirements have been reviewed and considered. Support for this statement must include:

(a) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and

(b) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.

c. An actuarial memorandum prepared, dated, and signed by the member of the academy of actuaries must be included and must address and support each specific item required as part of the actuarial certification and provide at least the following information:

(1) An explanation of the review performed by the actuary prior to making the statements in paragraphs 2 and 3 of subdivision b.

(2) A complete description of pricing assumptions.

(3) Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in paragraph 1 of subdivision b of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans, or states must be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

(4) A demonstration that the gross premiums include the minimum composite margin specified in paragraph 4 of subdivision b.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

#### **45-06-05.1-16. Reserve standards.**

1. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with North Dakota Century Code section 26.1-35-02. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

- a. Definition of insured events;
- b. Covered long-term care facilities;
- c. Existence of home convalescence care coverage;
- d. Definition of facilities;
- e. Existence or absence of barriers to eligibility;
- f. Premium waiver provision;
- g. Renewability;
- h. Ability to raise premiums;
- i. Marketing method;
- j. Underwriting procedures;
- k. Claims adjustment procedures;
- l. Waiting period;
- m. Maximum benefit;
- n. Availability of eligible facilities;
- o. Margins in claim costs;
- p. Optional nature of benefit;
- q. Delay in eligibility for benefit;
- r. Inflation protection provisions; and
- s. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

2. When long-term care benefits are provided other than as in subsection 1, reserves shall be determined in accordance with ~~section 45-03-15-01~~generally accepted accounting and reserve practices.

**History:** Effective March 1, 2004; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

**45-06-05.1-17. ~~Loss ratio~~Life insurance long-term care benefits.**

1. ~~This section shall apply to all long-term care insurance policies or certificates except those covered under sections 45-06-05.1-08 and 45-06-05.1-18.~~

- ~~2. Benefits under long term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a manner which provides for adequate reserving of the long term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:~~
- ~~a. Statistical credibility of incurred claims experience and earned premiums;~~
  - ~~b. The period for which rates are computed to provide coverage;~~
  - ~~c. Experienced and projected trends;~~
  - ~~d. Concentration of experience within early policy duration;~~
  - ~~e. Expected claim fluctuation;~~
  - ~~f. Experience refunds, adjustments, or dividends;~~
  - ~~g. Renewability features;~~
  - ~~h. All appropriate expense factors;~~
  - ~~i. Interest;~~
  - ~~j. Experimental nature of the coverage;~~
  - ~~k. Policy reserves;~~
  - ~~l. Mix of business by risk classification; and~~
  - ~~m. Product features such as long elimination periods, high deductibles, and high maximum limits.~~
- ~~3. Subsection 2 shall not apply to life insurance policies that accelerate benefits for long term care.~~ A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:
- a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
  - b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of North Dakota Century Code sections 26.1-33-18 through 26.1-33-28;
  - c. The policy meets the disclosure requirements of subsections 4, 5, and 6 of North Dakota Century Code section 26.1-45-09;
  - d. Any policy illustration that meets the applicable requirements of the national association of insurance commissioners life insurance illustrations model regulation; and
  - e. An actuarial memorandum is filed with the insurance department that includes:
    - (1) A description of the basis on which the long-term care rates were determined;
    - (2) A description of the basis for the reserves;
    - (3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;



- (4) A description and a table of each actuarial assumption used. For expenses, an insurer must include a percentage of premium dollars per policy and dollars per unit of benefits, if any;
- (5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- (6) The estimated average annual premium per policy and the average issue age;
- (7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
- (8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

**History:** Effective March 1, 2004; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

**45-06-05.1-18. Premium rate schedule increases.**

1. This section shall apply as follows:
  - a. Except as provided in subdivision b, this section applies to any long-term care policy or certificate issued in this state on or after September 1, 2004.
  - b. For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following March 1, 2005.
2. An insurer shall ~~provide notice~~request approval of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least thirty days prior to the notice to the policyholders and shall include:
  - a. Information required by section 45-06-05.1-07;
  - b. Certification by a qualified actuary that:
    - (1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and
    - (2) The premium rate filing is in compliance with the provisions of this section;
  - c. An actuarial memorandum justifying the rate schedule change request that includes:
    - (1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;



- (a) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;
  - (b) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
  - (c) The projections shall demonstrate compliance with subsection 3; and
  - (d) For exceptional increases:
    - [1] The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
    - [2] In the event the commissioner determines as provided in subdivision d of subsection 1 of section 45-06-05.1-02 that offsets may exist, the insurer shall use appropriate net projected experience;
- (2) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
  - (3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
  - (4) A statement that policy design, underwriting, and claims adjudication practices have been taken into consideration; ~~and~~
  - (5) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and
  - (6) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in paragraph 4 of subdivision b of subsection 2 of section 45-06-05.1-08.1 is projected to be exhausted.
- d. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and
  - e. Sufficient information for review and approval of the premium rate schedule increase by the commissioner.
3. All premium rate schedule increases shall be determined in accordance with the following requirements:
- a. Exceptional increases shall provide that seventy percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
  - b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
    - (1) The accumulated value of the initial earned premium times fifty-eight percent;

- (2) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;
    - (3) The present value of future projected initial earned premiums times fifty-eight percent; and
    - (4) Eighty-five percent of the present value of future projected premiums not in paragraph 3 on an earned basis;
  - c. In the event that a policy form has both exceptional and other increases, the values in paragraphs 2 and 4 of subdivision b will also include seventy percent for exceptional rate increase amounts; and
  - d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate ~~for contract reserves as specified in section 45-03-15-04~~ permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
4. For each rate increase that is implemented, the insurer shall file for approval by the commissioner updated projections, as defined in paragraph 1 of subdivision c of subsection 2, annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection 11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
5. If any premium rate in the revised premium rate schedule is greater than two hundred percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in paragraph 1 of subdivision c of subsection 2, shall be filed for approval by the commissioner every five years following the end of the required period in subsection 4. For group insurance policies that meet the conditions in subsection 11, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.
6.
  - a. If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection 3, the commissioner may require the insurer to implement any of the following:
    - (1) Premium rate schedule adjustments; or
    - (2) Other measures to reduce the difference between the projected and actual experience.
  - b. In ~~determine~~determining whether the actual experience adequately matches the projected experience, consideration should be given to paragraph 5 of subdivision c of subsection 2, if applicable.
7. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:
  - a. A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the commissioner may impose the condition in subsection 8; and

- b. The original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to subsection 3 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent been used in the calculations described in paragraphs 1 and 3 of subdivision b of subsection 3.
- 8.
- a. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve months following each increase to determine if significant adverse lapsation has occurred or is anticipated:
    - (1) The rate increase is not the first rate increase requested for the specific policy form or forms;
    - (2) The rate increase is not an exceptional increase; and
    - (3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.
  - b. In the event significant adverse lapsation has occurred and is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.
    - (1) The offer shall:
      - (a) Be subject to the approval of the commissioner;
      - (b) Be based on actuarially sound principles, but not be based on attained age; and
      - (c) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
    - (2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:
      - (a) The maximum rate increase determined based on the combined experience; and
      - (b) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent.
9. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subsection 8, prohibit the insurer from either of the following:
- a. Filing and marketing comparable coverage for a period of up to five years; or
  - b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

10. Subsections 1 through 9 shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subsection 2 of section 45-06-05.1-02, if the policy complies with all of the following provisions:
- a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;
  - b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
    - (1) North Dakota Century Code sections 26.1-33-18 through 26.1-33-28; and
    - (2) North Dakota Century Code ~~chapter 26.1-34; and~~
    - ~~(3) Sections 45-04-02-01 through 45-04-02-08; and~~ section 26.1-34-02.
  - c. The policy meets the disclosure requirements of subsections 4, 5, and 6 of North Dakota Century Code section 26.1-45-09;
  - d. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:
    - (1) Policy illustrations as required by ~~sections 45-04-01.1-01 through 45-04-01.1-10 plus bulletins 96-2 and 97-2~~ chapter 45-04-01.1; and
    - (2) Disclosure requirements in ~~sections 45-04-02-01 through 45-04-02-08; and~~ chapter 45-04-02.
  - e. An actuarial memorandum is filed with the insurance department that includes:
    - (1) A description of the basis on which the long-term care rates were determined;
    - (2) A description of the basis for the reserves;
    - (3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
    - (4) A description and a table of each actuarial assumption used. For expenses, an insurer must include a percentage of premium dollars per policy and dollars per unit of benefits, if any;
    - (5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
    - (6) The estimated average annual premium per policy and the average issue age;
    - (7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
    - (8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

11. Subsections 6 and 8 shall not apply to group insurance policies as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 when:
  - a. The policies insure two hundred fifty or more persons and the policyholder has five thousand or more eligible employees of a single employer; or
  - b. The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than twenty percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

**History:** Effective March 1, 2004; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

#### **45-06-05.1-21. Standards for marketing.**

1. Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:
  - a. Establish marketing procedures and agent training requirements to assure that:
    - (1) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and
    - (2) Excessive insurance is not sold or issued.
  - b. Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
  - c. Provide copies of the disclosure forms required in subsection 3 of section 45-06-05.1-07 (appendices B and F) to the applicant.
  - d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.
  - e. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with subsection 1.
  - f. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that the program is available and the name, address, and telephone number of the program.
  - g. For long-term care health insurance policies and certificates, use the terms "noncancelable" or "level premium" only when the policy or certificate conforms to subdivision c of subsection 1 of section 45-06-05.1-04.
  - h. Provide an explanation of contingent benefit upon lapse provided for in subdivision c of subsection 4 of section 45-06-05.1-24 and, if applicable, the additional contingent benefit

upon lapse provided to policies with fixed or limited premium payment periods in subdivision d of subsection 4 of section 45-06-05.1-24.

2. In addition to the practices prohibited in North Dakota Century Code section 26.1-04-03, the following acts and practices are prohibited:
  - a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.
  - b. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
  - c. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.
  - d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.
3.
  - a. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in subdivision b of subsection 3 of North Dakota Century Code section 26.1-45-01, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.
  - b. The insurer shall file with the insurance department the following material:
    - (1) The policy and certificate;
    - (2) A corresponding outline of coverage; and
    - (3) All advertisements requested by the insurance department.
  - c. The association shall disclose in any long-term care insurance solicitation:
    - (1) The specific nature and amount of the compensation arrangements, including all fees, commissions, administrative fees, and other forms of financial support, that the association receives from endorsement or sale of the policy or certificate to its members; and
    - (2) A brief description of the process under which the policies and the insurer issuing the policies were selected.
  - d. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.
  - e. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

- f. The association shall also:
  - (1) At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;
  - (2) Actively monitor the marketing efforts of the insurer and its agents; and
  - (3) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.
  - (4) Paragraphs 1 through 3 shall not apply to qualified long-term care insurance contracts.
- g. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in this subsection.
- h. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subsection.
- i. Failure to comply with the filing and certification requirements of this section constitutes an unfair trade practice in violation of North Dakota Century Code section 26.1-04-03.

**History:** Effective March 1, 2004; [amended effective October 1, 2019.](#)

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

**45-06-05.1-24. Nonforfeiture benefit requirement.**

- 1. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- 2. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of North Dakota Century Code section 26.1-45-14:
  - a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection 5; and
  - b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.
- 3. If the offer required to be made under North Dakota Century Code section 26.1-45-14 is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. [Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in subdivision d of subsection 4 still applies.](#)
- 4.
  - a. After rejection of the offer required under North Dakota Century Code section 26.1-45-14, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.
  - b. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

- c. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age and the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase	
Issue Age	Percentage Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%



82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

- d. A contingent benefit on lapse also must be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within one hundred twenty days of the due date of the premium so increased, and the ratio in paragraph 2 of subdivision f is forty percent or more. Unless otherwise required, policyholders must be notified at least thirty days prior to the due date of the premium reflecting the rate increase.

<u>Triggers for a Substantial Premium Increase</u>	
<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
<u>Under 65</u>	<u>50%</u>
<u>65-80</u>	<u>30%</u>
<u>Over 80</u>	<u>10%</u>

This provision is in addition to the contingent benefit provided by subdivision c and where both are triggered, the benefit provided must be at the option of the insured.

- e. On or before the effective date of a substantial premium increase as defined in subdivision c, the insurer shall:
- (1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
  - (2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection 5. This option may be elected at any time during the one hundred twenty-day period referenced in subdivision c; and
  - (3) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period referenced in subdivision c shall be deemed to be the election of the offer to convert in paragraph 2 unless the automatic option in paragraph 3 of subdivision f applies.
- f. On or before the effective date of a substantial premium increase as defined in subdivision d, the insurer shall:
- (1) Offer to reduce policy benefits provided by the current coverage so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the one hundred twenty-day period referenced in subdivision d; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty-day period referenced in subdivision d is deemed to be the election of the offer to convert in paragraph 2 if the ratio is forty percent or more.

g. For any long-term care policy issued in this state on or after March 1, 2020:

(1) If the policy or certificate was issued at least twenty years before the effective date of the increase, a value of zero percent must be used in place of all values in the above table; and

(2) Values above one hundred percent in the table in subdivision c must be reduced to one hundred percent.

5. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subdivision c of subsection 4 but not subdivision d of subsection 4, are described in this subsection:

a. For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty, and at least three percent per year beyond age fifty.

b. For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subdivision c.

c. The standard nonforfeiture credit will be equal to one hundred percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection 6.

d. (1) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) Notwithstanding paragraph 1, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(a) The end of the tenth year following the policy or certificate issue date; or

(b) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

e. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

6. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.
7. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.
8. The requirements set forth in this section shall become effective twelve months after adoption of this provision and shall apply as follows:
  - a. Except as provided in ~~subdivision~~subdivisions b and c, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.
  - b. For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01, which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.
  - c. The last sentence in subsection 3 and subdivisions d and f of subsection 4 apply to any long-term care insurance policy or certificate issued in this state after six months after their adoption, except new certificates on a group policy as defined in subdivision a of subsection 3 of North Dakota Century Code section 26.1-45-01 one year after adoption.
9. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the ~~loss ratio~~ requirements of section 45-06-05.1-17 or 45-06-05.1-18, treating the policy as a whole.
10. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subdivision c or d of subsection 4, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.
11. A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:
  - a. The nonforfeiture provision shall be appropriately captioned;
  - b. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form; and
  - c. The nonforfeiture provision shall provide at least one of the following:
    - (1) Reduced paid-up insurance;
    - (2) Extended term insurance;
    - (3) Shortened benefit period; or
    - (4) Other similar offerings approved by the commissioner.

**History:** Effective March 1, 2004; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-45

## APPENDIX B

### Personal Worksheet

#### Long-Term Care Insurance Personal Worksheet

~~People buy long-term care insurance for many reasons. Some do not want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others do not want their family to have to pay for care or do not want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.~~

~~By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.~~

#### **Premium Information**

~~Policy Form Numbers \_\_\_\_\_~~

~~The premium for the coverage you are considering will be [\$ \_\_\_\_\_ per month, or \$ \_\_\_\_\_ per year,] [a one-time single premium of \$ \_\_\_\_\_.]~~

~~**Type of Policy** (noncancelable/guaranteed renewable): \_\_\_\_\_~~

~~**The Company's Right to Increase Premiums:** \_\_\_\_\_~~

~~[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]~~

#### **Rate Increase History**

~~The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]~~

#### **Questions Related to Your Income**

~~How will you pay each year's premium?~~

~~From My Income                       From My Savings/Investments                       My Family Will Pay~~

~~Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?~~

~~What is your annual income? (check one)~~

<del><input type="checkbox"/> Under \$10,000</del>	<del><input type="checkbox"/> \$[10,000-20,000]</del>
<del><input type="checkbox"/> \$[20,000-30,000]</del>	<del><input type="checkbox"/> \$[30,000-50,000]</del>
	<del><input type="checkbox"/> Over \$50,000</del>

How do you expect your income to change over the next 10 years? (check one)

No change       Increase       Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one)       Yes       No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

From My Income       From My Savings/Investments       My Family Will Pay

*The national average annual cost of care in [insert year] was [insert \$ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.*

What elimination period are you considering? Number of days \_\_\_\_\_ Approximate cost \$ \_\_\_\_\_ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

From My Income       From My Savings/Investments       My Family Will Pay

### Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

Under \$20,000       \$20,000-\$30,000       \$30,000-\$50,000       Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

Stay about the same       Increase       Decrease

*If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.*

## Disclosure Statement

The answers to the questions above describe my financial situation.  
**Or**  
 I choose not to complete this information.  
(Check one.)

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history, and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history, and potential for premium increases in the future.] **I understand the above disclosures. I understand that the rates for this policy may increase in the future.**  
(This box must be checked.)

Signed: \_\_\_\_\_  
(Applicant) (Date)

I explained to the applicant the importance of completing this information.

Signed: \_\_\_\_\_  
(Applicant) (Date)

Agent's Printed Name: \_\_\_\_\_ }

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed: \_\_\_\_\_  
(Applicant) (Date)

*The company may contact you to verify your answers.*

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this [policy] [certificate] [rider] to give you some important facts about premiums and premium increases and to ask you some important questions to help you and the company decide if you should buy this [policy] [certificate] [rider]. Long-term care insurance can be expensive and it may not be right for everyone.

**Premium Information**

**The premium for the coverage you are considering will be [\$ \_\_\_\_\_ per [insert payment interval] or a total of [\$ \_\_\_\_\_ per year] [a one-time single premium of \$ \_\_\_\_\_.]**

**The premium quoted in this worksheet is not guaranteed and may change during the underwriting process and in the future while this [policy] [certificate] [rider] is in force.**

**Type of Policy and The Company's Right to Increase Premiums on the Coverage You Choose:**

[Noncancellable - The company **cannot** increase your premiums on this [policy] [certificate] [rider].]

[Guaranteed renewable - The company **can** increase your premiums on this [policy] [certificate] [rider] in the future if it increases the premiums for all [policies] [certificates] [riders] like yours in this state.]

[Paid-up - This [policy] [certificate] [rider] will be paid-up after you have paid all of the premiums specified in your [policy] [certificate] [rider].]

**Premium Increase History**

[Name of company] has sold long-term care insurance since [year] and has sold this [policy] [certificate] [rider] since [year].

[The company has never increased its premiums for any long-term care [policy] [certificate] [rider] it has sold in this state or any other state.]

[The company has not increased its premiums for this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in this state or any other state in the last 10 years.]

[The company has increased its premiums on this [policy] [certificate] [rider] or similar [policies] [certificates] [riders] in the last 10 years. A summary of those premium increases follows.]

**Questions About Your Income**

You do **not** have to answer the questions that follow. They are intended to make sure you have thought about how you'll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

**What resources will you use to pay your premium?**

\_\_\_\_\_ Current income from employment \_\_\_\_\_ Current income from investments \_\_\_\_\_ Other current income

\_\_\_\_\_ Savings \_\_\_\_\_ Sell investments \_\_\_\_\_ Sell other assets \_\_\_\_\_ Money from my family \_\_\_\_\_ Other \_\_\_\_\_

*If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this [policy] [certificate] [rider] if the premiums will be more than 7% of your income.*

**Could you afford to keep this [policy] [certificate] [rider] if your spouse or partner dies first?**

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Had not thought about it \_\_\_\_\_ Do not know \_\_\_\_\_ Does not apply

**What would you do if the premiums went up, for example, by 50%?**

\_\_\_\_\_ Pay the higher premium \_\_\_\_\_ Call the company/agent \_\_\_\_\_ Reduce benefits

\_\_\_\_\_ Drop the [policy] [certificate] [rider] \_\_\_\_\_ Do not know

**What is your household annual income from all sources? (check one)**

[Less than \$10,000]     [\$10,000-\$19,999]     [\$20,000-\$29,999]     [\$30,000-\$50,000]  
 [More than \$50,000]

**Do you expect your income to change over the next 10 years? (check one)**

No     Yes, expect increase     Yes, expect decrease

**If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?**

Yes     No     Do not know

**Will you buy inflation protection? (check one)**

Yes     No

*Inflation may increase the cost of long-term care in the future.*

**If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?**

From my income     From savings     From investments     Sell other assets  
 Money from my family     Other

*The national average annual cost of long-term care in [insert year] was [insert \$ amount], but this figure varies across the country. In 10 years the national average annual cost would be about [insert \$ amount] if costs increase 5% annually.*

**What [elimination period] [waiting period] [cash deductible] are you considering?**

[Number of days \_\_\_\_\_ in [elimination period] [waiting period]

Approximate cost of care for that period: \$ \_\_\_\_\_  
(\$xxx per day times number of days in [elimination period] [waiting period], where "xxx" represents the most recent estimate of the national daily average cost of long-term care)]

[Cash Deductible \$ \_\_\_\_\_]

**How are you planning to pay for your care during the [elimination period] [waiting period] [deductible period]? (check all that apply)**

From my income     From my savings/investments     My family will pay

**Questions About Your Savings and Investments**

**Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)**

[Less than \$20,000]     [\$20,000-\$29,999]     [\$30,000-\$50,000]     [More than \$50,000]

**Do you expect your assets to change over the next 10 years? (check one)**

No     Yes, expect to increase     Yes, expect to decrease

*If you are buying this [policy] [certificate] [rider] to protect your assets and your assets are less than \$50,000, experts suggest you think about other ways to pay for your long-term care.*



**Disclosure Statement**

The answers to the questions above describe my financial situation.

**Or**

I choose not to complete this information.

(Check one.)

I agree that the company and/or its agent (below) has reviewed this worksheet with me, including the premium, premium increase history, and potential for premium increases in the future. I understand the information contained in this worksheet. (This box must be checked.)

Signed:

\_\_\_\_\_ (Applicant)

\_\_\_\_\_ (Date)

I explained to the applicant the importance of completing this information.

Signed:

\_\_\_\_\_ (Agent)

\_\_\_\_\_ (Date)

Agent's Printed Name:

\_\_\_\_\_

[In order for us to process your application, please return this signed worksheet to [name of company], along with your application.]

[My agent has advised me that this long-term care insurance [policy] [certificate] [rider] does not seem to be suitable for me. However, I still want the company to consider my application.]

Signed:

\_\_\_\_\_ (Applicant)

\_\_\_\_\_ (Date)

Someone from the company may contact you to discuss your answers and the suitability of this [policy] [certificate] [rider] for you.

## APPENDIX C

### Disclosure Form

#### Things You Should Know Before You Buy Long-Term Care Insurance

- Long-Term Care Insurance**
  - A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
  - [You should not buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]
  - The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare**
  - Medicare does **not** pay for most long-term care.
- Medicaid**
  - Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
  - Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
  - When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
  - Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
- Shopper's Guide**
  - Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance". Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
- Counseling**
  - Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
- Facilities**
  - Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

**APPENDIX E**

**Sample Claims Denial Format**

**Claims Denial Reporting Form  
Long-Term Care Insurance**

**For the State of** \_\_\_\_\_

**For the Reporting Year of** \_\_\_\_\_

Company Name: \_\_\_\_\_ Due: June 30 annually

Company Address: \_\_\_\_\_

Company NAIC Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Line of Business:            Individual                            Group

**Instructions**

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. Indicate the manner of reporting by checking one of the boxes below:

Per Claimant - Counts each individual who makes one or a series of claim requests.

Per Transaction - Counts each claim payment request.

"Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable pre-existing condition. It does not include a request for payment that is in excess of the applicable contractual limits.

In-force Data

		<b>State Data</b>	<b>Nationwide Data<sup>1</sup></b>
1	<u>Total Number of In-force Policies [Certificates] as of December 31st</u>		

Claims and Denial Data

		<b>State Data</b>	<b>Nationwide Data<sup>1</sup></b>
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid Due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid Due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for		

	Reporting Purposes (line 2 minus line 3 minus line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (line 5 divided by line 1)		
7	Number of Long-Term Care Claims Denied Due to:		
8	Long-Term Care Services Not Covered Under the policy <sup>2</sup>		
9	Provider/Facility Not Qualified Under the Policy <sup>3</sup>		
10	Benefit Eligibility Criteria Not Met <sup>4</sup>		

11 Other

1. The nationwide data may be viewed as a more representative and credible indicator where the ~~date~~data for claims reported and denied for your state are small in number.
2. Example - Home health care claim filed under a nursing home only policy.
3. Example - A facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples - A benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

## APPENDIX F

### Potential Rate Increase Disclosure Form

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

**Insurers shall provide all of the following information to the applicant:**

#### Long-Term Care Insurance Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and approved for an increase [is][are] [on the application] [\$\_\_\_\_\_].
2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): \_\_\_\_\_.

4. Potential Rate Revisions:

**This policy is Guaranteed Renewable.** This means that the rates for this product may be increased in the future. Your rates CANNOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

**If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:**

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.\* (This option may be available if you do not purchase a separate nonforfeiture option.)

#### Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you did not buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here is how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

**Example:**

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy.)

**Contingent Nonforfeiture  
Cumulative Premium  
Increase Over Initial Premium  
That Qualifies for Contingent  
Nonforfeiture**

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

<b>Issue Age</b>	<b>Percentage Increase Over Initial Premium</b>
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%

71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which subdivisions d and f of subsection 4 of section 45-06-05.1-24 are applicable.]

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

<u>Triggers for a Substantial Premium Increase</u>	
<u>Issue Age</u>	<u>Percent Increase Over Initial Premium</u>
<u>Under 65</u>	<u>50%</u>
<u>65-80</u>	<u>30%</u>
<u>Over 80</u>	<u>10%</u>

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- a. The total lifetime amount of benefits your reduced paid-up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy

becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

**Example:**

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.



**CHAPTER 45-06-16**  
**SHORT-TERM LIMITED-DURATION INSURANCE**

Section

<u>45-06-16-01</u>	<u>Definitions</u>
<u>45-06-16-02</u>	<u>Application Requirements</u>
<u>45-06-16-03</u>	<u>Disclosure Requirements</u>
<u>45-06-16-04</u>	<u>Standards of Marketing</u>

**45-06-16-01. Definitions.**

1. "Application" includes an application for individual coverage or a group enrollment form.
2. "Short-term limited-duration health insurance plan" means health insurance coverage provided pursuant to an insurance policy or group certificate of insurance that has an expiration date specified in the policy that is no longer than six months after the original effective date of the policy and, taking into account any renewals or extensions, has a duration of not more than twelve months in total.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 26.1-36-38

**Law Implemented:** NDCC 26.1-36-49

**45-06-16-02. Application requirements.**

All applications for short-term limited-duration insurance policies must contain clear and unambiguous questions designed to ascertain the reason for the health condition of the applicant as follows:

1. Do you have comprehensive major medical coverage in force as of the date of this application?
2. Are you aware that this insurance coverage is not comprehensive major medical coverage?
3. Why are you purchasing a short-term limited-duration plan? (Please check all that apply)
  - a. I am not eligible for Affordable Care Act marketplace tax subsidies.
  - b. I cannot afford an Affordable Care Act marketplace plan.
  - c. I do not use a lot of health care; therefore, I do not feel I need a comprehensive major medical plan.
  - d. Other.
4. Do you understand this policy may not have network doctors and therefore may result in a bill for additional charges not covered by a doctor that is out-of-network with this plan?

**History:** Effective October 1, 2019.

**General Authority:** NDCC 26.1-36-38

**Law Implemented:** NDCC 26.1-36-49

**45-06-16-03. Disclosure requirements.**

1. Disclosure statement. All short-term limited-duration policies as defined under North Dakota Century Code section 26.1-36-49 must contain the following disclosure on the front cover page of the policy, the certificate of coverage, and the application in large print:

THIS IS NOT A COMPREHENSIVE MAJOR MEDICAL INSURANCE POLICY.

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH CERTAIN FEDERAL MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. PLEASE CAREFULLY REVIEW THE TERMS OF YOUR POLICY TO MAKE SURE YOU ARE AWARE OF ANY EXCLUSIONS OR LIMITATIONS REGARDING COVERAGE OF PRE-EXISTING CONDITIONS OR HEALTH BENEFITS (SUCH AS HOPITALIZATION, EMERGENCY SERVICES, MATERNITY CARE, PREVENTATIVE CARE, PRESCRIPTION DRUGS, HABILITATIVE AND REHABILITATIVE CARE, AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR POLICY MIGHT ALSO HAVE LIFETIME AND/OR ANNUAL DOLLAR LIMITS ON HEALTH BENEFITS. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MAY HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO OBTAIN OTHER HEALTH INSURANCE COVERAGE.

2. Outline of coverage. The outline of coverage must provide the following information:

- a. Types of benefits provided.
- b. Cost-sharing provisions and maximum limits.
- c. Describe how benefit payments are determined.
- d. Exclusions and limitations.
- e. Renewability provisions.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 26.1-36-38

**Law Implemented:** NDCC 26.1-36-49

#### **45-06-16-04. Standards of marketing.**

An issuer through its producers, shall:

1. Provide an outline of coverage to applicants at the time application is presented to the prospective applicant and shall obtain an acknowledgment of receipt of the outline from the applicant.
2. Establish marketing procedures to assure any comparison of policies by its agents or other producers will be fair and accurate.
3. Establish marketing procedures to assure full disclosure is given to the insured.
4. Establish auditable procedures for verifying compliance with this section.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 26.1-36-38

**Law Implemented:** NDCC 26.1-36-49

## CHAPTER 45-10-02

### 45-10-02-01. Definitions.

For the purposes of this chapter, the following definitions apply in addition to the definitions set forth in North Dakota Century Code chapter 23-37:

1. "Antifreeze" is not a petroleum product.
2. "Department" means the department of environmental quality.
3. "Farm tank" means a tank located on a tract of land devoted to the production of crops or for raising animals and associated residences and improvements. A farm tank must be located on the farm property.
- 3-4. "Portable tank" means any storage tank, along with its piping and wiring, that is not stationary or affixed including, but not limited to, tanks which are on skids.
- 4-5. "Residential tank" means a tank located on property used primarily for dwelling purposes.
- 5-6. "Surface impoundment" means a natural topographic depression, manmade excavation, or diked area formed primarily of earthen materials.
- 6-7. Storage tanks used for collecting crude oil are considered flowthrough process tanks and are excluded from coverage.

**History:** Effective November 25, 1991; amended effective June 1, 1994; April 1, 2014; October 1, 2019.

**General Authority:** NDCC 23-37-05, 28-32-02

**Law Implemented:** NDCC 23-37

### 45-10-02-04. Notification of release procedures.

Upon receiving notice of a release, the administrator shall:

1. Verify that the tank and all other tanks owned or operated by the operator are registered with the fund.
2. Record the release information in the registration file for the location.
3. Verify that the ~~state~~-department ~~of health~~ has received notice of the release.
4. If the owner or operator has not registered all of the tanks owned and operated by the operator at the location of the release, send a letter of denial to the owner or operator with a copy to the ~~state~~-department ~~of health~~ and close the file.
5. Obtain verification from the owner or operator that the affected tank, equipment, components, material, or dispenser is compatible with and ~~meet~~meets state requirements for the petroleum product stored and dispensed. If not compatible, send letter of denial to the owner operator with a copy to the ~~state~~-department ~~of health~~ and close file.
6. If all tanks are registered and the affected tank, piping, fitting, or dispenser is compatible, notify the owner of the fund's claim filing procedures and send the tank owner or operator the fund's tank release guidelines with an application for reimbursement.

**History:** Effective November 25, 1991; amended effective June 1, 1994; August 1, 2000; April 1, 2014; October 1, 2019.

**General Authority:** NDCC 23-37-05, 28-32-02

**45-10-02-06. Reimbursement.**

1. The fund will reimburse only reasonable and necessary eligible cleanup expenses as determined by the administrator in consultation with the ~~state~~ department of ~~health~~ and only if all tanks are properly registered prior to the discovery of the release.
2. No payment will be made from the fund unless a completed application form has been received by the administrator.
3. Eligible expenses for corrective action include the following:
  - a. Labor.
  - b. Testing.
  - c. Use of machinery.
  - d. Materials and supplies.
  - e. Professional services.
  - f. Expenses incurred through direction of the ~~state~~ department of ~~health~~.
  - g. Any other expenses the administrator and the board deem to be reasonable and necessary to remedy cleanup of the release and satisfy liability to any third party.
  - h. Consultant fees if authorized by the ~~state~~ department of ~~health~~.
4. The following will not be considered eligible expenses under this regulation:
  - a. The cost of replacement, repair, and maintenance of affected tanks and associated piping.
  - b. Pumping out of any product, including water, from any tanks which need to be removed.
  - c. The cost of upgrading existing affected tanks and associated piping.
  - d. The loss of income, profits, or petroleum product.
  - e. Decreased property value.
  - f. Bodily injuries or property damages except for injuries or damages suffered by third parties.
  - g. Attorney's fees.
  - h. Costs associated with preparing, filing, and prosecuting an application for reimbursement or assistance under this regulation.
  - i. The costs of making improvements to the facility beyond those that are required for corrective action, including replacing concrete, asphalt, equipment, or buildings.
  - j. Any cleanup costs resulting from negligence or misconduct on the part of the owner or operator.
  - k. Marked-up costs.
  - l. Costs in excess of those considered reasonable by the ~~fund~~ administrator.

- m. Fines or penalties imposed by order of federal, state, or local government.
  - n. Finance charges, interest charges, or late payment charges.
5. To determine what expenses are reasonable and necessary, the owner, operator, or landowner must bid the excavation and consultant work. The lowest bid that meets the requirements of the ~~state~~-department ~~of health~~ will be deemed by the ~~fund~~ administrator to be the reasonable cost for that project. The bid must be submitted according to the fund's excavation and consultant worksheets. Additional work over and above the original bid will be reimbursed according to unit costs on the original bid.
  6. The administrator may provide partial payments prior to the final determination of the amount of the loss, if it is determined that the cleanup is proceeding according to the proposed workplan of the ~~state~~-department ~~of health~~ for the site assessment. The payment may be made to the owner, operator, or landowner or that person's assigned representative if the appropriate assignment form is submitted to the administrator with appropriate documentation verifying that the work has been completed by the assignee.
  7. ~~All claims for payment~~ Requests for reimbursement are subject to the availability of funds in the petroleum tank release compensation fund and must be submitted, with the completed worksheets, no later than one year after the work unit or task has been completed to be eligible.
  8. Prior to payment for any loss, the owner, operator, or landowner shall subrogate to the fund all rights, claims, and interest which the owner, operator, or landowner has or may have against any party, person, persons, property, corporation, or other entity liable for the subject loss, and shall authorize the fund to sue, compromise, or settle in the name of the owner, operator, or landowner or otherwise, all such claims. The subrogation agreement required by this section must be prescribed and produced by the administrator.
  9. Reimbursement will be considered when the owner, operator, or landowner has submitted complete excavation or consultant worksheets along with legible copies of all invoices and a description of the work performed.
  10. The owner, operator, or landowner must submit, prior to any payment, evidence that the amounts shown on the invoices for which the payment is requested were either paid in full by the owner, operator, or landowner or, if the owner, operator, or landowner has assigned the right to receive payment from the fund, that a contractor hired has expended time and materials for which payment must be made. This must include documentation that the work has been completed by the assignee.
  11. Prior to payment, the administrator must be satisfied that the corrective action taken has met all state regulations and that the corrective action has satisfied public health, welfare, and environmental concerns.

**History:** Effective November 25, 1991; amended effective June 1, 1994; August 1, 2000; December 1, 2001; April 1, 2014; October 1, 2019.

**General Authority:** NDCC 23-37-05, 28-32-02

**Law Implemented:** NDCC 23-37-18, 23-37-20, 23-37-23, 23-37-24

#### **45-10-02-06.1. Reimbursement disputes.**

If the fund administrator denies or reduces payment to a tank owner, operator, or landowner, the tank owner, operator, or landowner may request a review by the board by filing a written request and supporting documentation with both the administrator and the board within thirty days of receiving a proof of loss. The board shall issue a written decision concerning the issues in dispute within thirty days of receiving the written notice and supporting documentation. The board's decision must provide the

basis of its decision. If after review by the board a dispute still exists, the claimant or the administrator may appeal the board decision to the commissioner within thirty days of the board's decision. The decision of the commissioner may be appealed under North Dakota Century Code chapter 28-32.

**History:** Effective August 1, 2000; amended effective December 1, 2001; October 1, 2019.

**General Authority:** NDCC 23-37-05, 28-32-02;

**Law Implemented:** NDCC 23-37

## CHAPTER 45-13-01

### 45-13-01-02. Product types - Definition.

Each line of insurance is defined to include the following products:

1. Life and annuity includes:

Annuity/institutional investment	Equity/interest indexed annuity
Credit life	Equity/interest indexed universal life
Deferred annuity	Structured settlement annuity
Endowment	Term life
Guaranteed investment contract/pension plan	Universal life
Immediate annuity	Whole life

and similar products relating to life and annuity matters.

2. Accident and health includes:

Accident	Hospital indemnity
Accidental death	Hospital and surgical
Accidental death and dismemberment	Intensive care
Cancer	Involuntary unemployment
Civilian health and medical program of the uniformed services supplement	Long-term care
Credit disability	Major medical
Critical illness	Managed care/excess loss
Dental	Medical expense
Disability income	Medicare supplement
Excess loss	Nursing home
Family leave	Organ and tissue transplant
Human immunodeficiency virus indemnity	Prescription drug
Home health care	Specified disease
	Sickness
	<a href="#">Stop-loss medical</a>
	Surgical expense
	Vision

and similar products relating to accident and health matters.

3. Property includes:

Aircraft cargo	Earthquake
Aircraft hull	Extended coverages
Allied lines	Fire
Auto commercial physical damage	Fire and allied lines
Auto private passenger physical damage	Flood
Baggage	Force placed
Boiler and machinery	Glass
Burglary and robbery	Lenders collateral
Business income	Livestock
Cargo	Money and securities
Commercial inland marine	Marine cargo
Commercial multi-peril	Marine hull
Commercial property	Mortgage guarantee
Credit	Multi-peril crop

Credit card  
Credit property  
Crime  
Crop  
Crop hail  
Crop supplements  
Difference in conditions  
Dwelling

Ocean marine  
Personal floater  
Personal inland marine  
Pet  
Rain  
Theft  
Vandalism  
Vendors single interest

and similar products relating to property matters.

4. Casualty includes:

Aircraft liability  
Asbestos abatement  
Auto commercial liability  
Auto private passenger liability  
Auto warranty contract  
Bail bonds  
Bonds  
Commercial excess liability  
Commercial general liability  
Commercial umbrella liability  
Contractual liability  
Directors and officers  
Design professional  
Employers liability  
Environmental impairment  
Errors and omissions  
Fidelity bonds  
Fidelity insurance  
Home warranty  
Legal expense  
Legal malpractice  
Liquor and dram shop liability

Medical malpractice  
Mechanical breakdown  
Personal excess liability  
Personal umbrella liability  
Personal liability  
Pollution liability  
Premises and operations  
Prepaid legal service  
Product liability  
Product recall  
Products and completed operations  
Professional liability  
Owners and contractors  
Railroad protective  
Ransom and extortion  
Stop gap  
Stop-loss liability  
Surety  
Title  
Vehicle service contracts  
Workers' compensation

and similar products relating to casualty matters.

5. Variable life and annuity includes:

Variable deferred annuity  
Variable immediate annuity  
Variable group annuity/pension plan  
Variable life

and similar products relating to variable life and annuity matters.

**History:** Effective January 1, 2000; [amended effective October 1, 2019.](#)

**General Authority:** NDCC 28-32-02

**Law Implemented:** NDCC 26.1-05-02.1



**TITLE 61**  
**STATE BOARD OF PHARMACY**



## OCTOBER 2019

### CHAPTER 61-01-01

#### 61-01-01-01. Organization of board of pharmacy.

1. **History and functions.** The 1890 legislative assembly passed pharmacy practice legislation codified as North Dakota Century Code chapter 43-15. This chapter requires the governor to appoint a state board of pharmacy. The board is responsible for examining and licensing applicants for licensure as pharmacists, for issuing permits to operate pharmacies, and for regulating and controlling the dispensing of prescription drugs and the practice of pharmacy for the protection of the health, welfare, and safety of the citizens of the state.
2. **Board membership.** The board consists of seven members appointed by the governor. Five members of the board must be licensed pharmacists, one member must be a registered pharmacy technician, and one member must represent the public and may not be affiliated with any group or profession that provides or regulates any type of health care. Board members serve five-year terms, with one of the pharmacist's terms expiring each year. The term of the public member and registered pharmacy technician member will expire five years from May eighth in the year of their appointment.
3. **Executive director.** The executive director of the board is appointed by the board and is responsible for administration of the activities of the board.
4. **Inquiries.** Inquiries regarding the board may be addressed to the executive director:

State Board of Pharmacy  
P.O. Box 1354  
Bismarck, ND 58502-1354

Street address - 1906 East Broadway Avenue  
Web address - [www.nodakpharmacy.com](http://www.nodakpharmacy.com)  
~~E-mail address - [www.ndboph@btinet.net](mailto:www.ndboph@btinet.net)~~  
Telephone - 701-328-9535  
Fax - 701-328-9536

**History:** Amended effective August 1, 1983; November 1, 1985; October 1, 1987; February 1, 1993; April 1, 1994; January 1, 2000; January 1, 2004; April 1, 2010; [October 1, 2019](#).

**General Authority:** NDCC 28-32-02.1

**Law Implemented:** NDCC 28-32-02.1

## CHAPTER 61-02-01

### 61-02-01-03. Pharmaceutical compounding standards.

The minimum standards and technical equipment to be considered as adequate shall include:

1. Definitions.

- a. "Active chemical or ingredient" refers to chemicals, substances, or other components of articles intended for use in the diagnostics, cure, mitigation, treatment, or prevention of diseases.
- b. "Aseptic processing" is the method of preparing pharmaceutical and medical products that involves the separate sterilization of the product and of the package, the transfer of the product into the container and closure of the container under ISO class 5 or superior conditions, and using procedures designed to preclude contamination of drugs, packaging, equipment, or supplies by micro-organisms during the process.
- c. "Beyond-use date" refers to the date placed on preparation label that is intended to indicate to the patient or caregiver a time beyond which the contents of the preparation are not recommended to be used. The beyond-use date is determined from the date and time compounding of the preparation is completed.
- d. "Component" is any ingredient used in the compounding of a drug product, including any that are used in its preparation, but may not appear on the labeling of such a product.
- e. "Compounded sterile preparation" (CSP) will include all of the following:
  - (1) Preparations prepared according to the manufacturer's labeled instructions and other manipulations when manufacturing sterile products that expose the original contents to potential contamination.
  - (2) Preparations containing nonsterile ingredients or employing nonsterile components or devices that must be sterilized before administration.
  - (3) Biologics, diagnostics, drugs, nutrients, and radiopharmaceuticals that possess either of the above two characteristics, and which include baths and soaks for live organs and tissues, implants, inhalations, injections, powders for injection, irrigations, metered sprays, and ophthalmic preparations.
- f. "Compounder or compounding personnel" is the pharmacist or other licensed or registered health care professional responsible for preparing the compounded preparations.
- g. "Compounding" is the preparation, mixing, assembling, packaging, and labeling of a drug or device in accordance to a licensed practitioner's prescription or medication order. Compounding does not include tablet splitting, reconstitution of oral or topical products as intended by the manufacturer, or repackaging of nonsterile dosage forms for redistribution, dispensing, or administration. Compounding includes:
  - (1) Preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns.
  - (2) The addition of one or more ingredients to a commercial product as a result of a licensed practitioner's prescription drug order.
  - (3) Preparation of drugs or devices for the purposes of, or as an incident to, research, teaching, or chemical analysis.

- (4) Categories of compounding.
- (a) Nonsterile simple. Should be conducted according to USP chapter 795.
  - (b) Sterile compounds. Risk levels of compounded sterile preparations. Risk levels are assigned according to the corresponding probability of contaminating a preparation with microbial organisms, spores, and endotoxins, or chemical and physical contamination such as foreign chemicals and physical matter. Preparations should be compounded according to USP chapter 797 based on the appropriate risk level.
  - (c) Radiopharmaceuticals. See article 61-05.
  - (d) Veterinary pharmaceuticals. Standards for veterinary pharmaceuticals are consistent with all parts of section 61-02-01-03.
- h. "Compounding supervisor" is a person who supervises and is responsible for the compounding and dispensing of a nonsterile or sterile preparation. This may be the pharmacist on duty or the pharmacist-in-charge.
- i. "Critical site" is a location that includes any component or fluid pathway surfaces (such as injection ports) or openings (such as opened ampules or needle hubs) exposed and at risk of direct contact with air, moisture, or touch contamination.
- j. "Direct and contiguous compounding area" refers to the specific area where a compound is prepared.
- k. "Disinfection" is the process by which the total number of micro-organisms is reduced to a safe level or eliminated by applying an agent to inanimate objects that destroys disease-causing pathogens or other harmful micro-organisms but may not kill bacterial and fungal spores.
- l. "Hazardous drug" is one of those which studies in animals or humans indicate that exposures to them have a potential for causing cancer, development, or reproductive toxicity or harm to organs.
- m. "ISO class" is a description of an atmospheric environment characterized by the number of particles of 0.5 microns or larger, within a cubic foot of air. "ISO class 5" atmospheric environment contains less than 100 particles, 0.5 microns or larger in diameter, per cubic foot of air.
- n. "Media fill test" refers to tests used to validate aseptic techniques of compounding personnel and of processes that ensure the personnel and processes used are able to produce sterile products without microbial contamination. Testing uses a microbiological growth medium to substitute for actual drug product to simulate admixture compounding in determining the quality of a person's technique.
- o. "NDC number" is the national drug code given to each drug separately and specifically approved by the food and drug administration for identification and reporting.
- p. "Preparation" is a drug dosage form, dietary supplement, or a finished device. It contains one or more substances formulated for use on or for the patient or consumer.
- q. "Primary engineering control (PEC)" refers to a device or room that provides an ISO class 5 or superior environment during the compounding process, including laminar airflow workbenches (LAFWs), biological safety cabinets (BSCs), compounding aseptic isolators (CAIs), and compounding aseptic containment isolators (CACIs).

- r. "Product" is a commercially manufactured drug or nutrient that has been evaluated for safety and efficacy by the food and drug administration, accompanied by full prescribing information.
  - s. "Repackaging" is the transfer of an ingredient from one container to another.
  - t. "Risk levels" of CSPs determine the level assigned that represent the probability that it will be contaminated with microbial organisms, spores, endotoxins, foreign chemicals, or other physical matter.
  - u. "Seventy percent sterile isopropyl" or IPA is an antimicrobial used to clean surfaces used in sterile preparations.
  - v. "Stability" means the extent to which a preparation retains, with specified limits, and throughout its period of storage and use, the same properties and characteristics it possessed at the time of compounding.
  - w. "US pharmacopeia (USP)" is the book of official compendia of standards for the United States.
2. General compounding.
- a. Responsibility of the compounder.
    - (1) Personnel engaging in compounding must be proficient, capable, and qualified to perform assigned duties in the compounding area while expanding the individual's knowledge of compounding through seminars or appropriate literature.
    - (2) Compounding personnel must be familiar with USP standards and North Dakota regulations, including:
      - (a) Certifying all prescriptions orders.
      - (b) Approving or rejecting all components, drug product containers, closures, in-process materials, and labeling ensuring preparations and ingredients are of acceptable strength, quality, and purity, with appropriate packaging.
      - (c) Preparing and reviewing all compounding records to assure that errors have not occurred in the compounding process and the finished product has expected qualities as well as implementing procedures to prevent cross-contamination.
      - (d) Assuring the proper maintenance, cleanliness, sanitization, and use of all equipment used in prescription compounding practice, including the direct and contiguous compounding area allowing for the compounding environment to be suitable for its intended purpose.
      - (e) Assuring that the drug product and components of drug products are not on the list of federally recognized drug products that have been withdrawn or removed from the market for public health reasons.
    - (3) Policies and procedures must be established concerning washing and donning the appropriate clothing specific to the type of process performed to protect the personnel from chemical exposures and prevent drug contamination.
  - b. Training. All compounding supervisors and all personnel involved in compounding must be well trained and must participate in current, relevant training programs. All training

activities will be covered by standard operating procedures and must be properly documented. Steps in the training procedure include:

- (1) Be familiar with pharmaceutical compounding and nonsterile compounding (USP 795), pharmaceutical compounding and sterile compounding (USP 797), hazardous drug compounding (USP 800), and pharmaceutical calculations in prescription compounding (USP 1160).
  - (2) Be familiar with all procedures relating to compounding specific to the individual's facility, equipment, personnel, compounding process, evaluation, packaging, storage, and dispensing.
  - (3) Compounding supervisors must be responsible to follow the instructions below to show that personnel are appropriately trained:
    - (a) Demonstrate compounding procedures to compounding personnel.
    - (b) Guide personnel through the compounding process with assistance.
    - (c) Observe personnel performing a compound without assistance but under supervision.
    - (d) Review the compound, correct mistakes, and answer questions concerning compounding and associated processes.
    - (e) Confirm verbal and functional knowledge of the personnel concerning compounding.
    - (f) Have personnel perform a compounding procedure without supervision, yet checking off the final preparation.
    - (g) If properly compounded and when satisfied, sign the documentation records confirming appropriate training.
    - (h) Continually monitor the work of the personnel, including calculations.
  - (4) The pharmacist on duty and the pharmacist-in-charge are ultimately responsible for the finished product.
- c. Procedures and documentation. Procedures must be developed for the facility, equipment, personnel, preparation, packaging, and storage of the compounded preparation to ensure accountability, accuracy, quality, safety, and uniformity in compounding. This allows for a compounder, whenever necessary, to systematically trace, evaluate, and replicate the steps included throughout the preparation process of a compounded preparation.
- d. Nonsterile drug compounding must meet the facility, equipment, packaging, storage, and beyond-use date standards set in USP chapter 795. Policies and procedures should be developed to ensure compliance with those standards.
- e. Compounding controls for nonsterile preparations.
- (1) The compounder must ensure that the written procedures for compounding are available electronically or in hard copy and assure the finished products have the correct identity, strength, quality, and purity.
  - (2) Procedures must be established that give a description of the following:

- (a) Components and their amounts.
  - (b) Order of component additives.
  - (c) Compounding process.
  - (d) Drug product.
  - (e) Required equipment and utensils, including container and closure systems.
- (3) The compounder will accurately weigh, measure, and subdivide all components as appropriate.
- (a) The compounder must check and recheck each procedure at each point of the process to ensure that each weight or measure is correct.
  - (b) If a component is transferred from the original container to another, the new container must be identified with the component, name, weight or measure, the lot or control number, the expiration or beyond-use date, and the transfer date.
- (4) The compounder must write procedures that describe the tests or examinations that prove uniformity and integrity of the compounded preparations.
- (5) Control procedures must be established to monitor the output and validate the performance of compounding personnel that affect variability of final preparations, such as:
- (a) Capsule weight variation.
  - (b) Adequacy of mixing to assure uniformity and homogeneity.
  - (c) Clarity, completeness, or pH of solutions.
- (6) The compounder must establish an appropriate beyond-use date for each compounded preparation.
- (7) Facilities engaging in compounding must have a specifically designated and adequate space for orderly compounding, including the placement and storage of equipment and materials.
- f. Labeling of nonsterile preparations.
- (1) The compounder's preparation label must contain all information required by North Dakota state law and accepted standards of practice found under chapter 61-04-06, prescription label requirements, plus the beyond-use date and assigned lot number.
  - (2) The compounder must label any excess compounded products so as to refer to the formula used.
  - (3) Preparations compounded in anticipation of a prescription prior to receiving a valid prescription should be made in a regularly used amount based on the history of prescriptions filled and they should be labeled with:
    - (a) Complete list of ingredients or preparation time and reference or established chemical name or generic name.
    - (b) Dosage form.
    - (c) Strength.



- (d) Preparation date and time.
  - (e) Inactive ingredients.
  - (f) Batch or lot number.
  - (g) Assigned beyond-use date.
  - (h) Storage conditions.
- (4) The compounder must examine the preparation for correct labeling after completion.
- g. Records and reports for nonsterile preparations.
- (1) Records must be maintained, including a hard copy of the prescription with formulation and compounding records.
  - (2) Adequate records of controlled substances used in compounds.
  - (3) All records must be kept for five years according to North Dakota state law and be available for inspection.
  - (4) Formulation record provides a consistent source document for preparing the preparation to allow another compounder to reproduce the identical prescription at a future date and must list:
    - (a) Name, strength, and dosage form of the preparation compounded.
    - (b) All ingredients and their quantities.
    - (c) Equipment needed to prepare the preparation, when appropriate.
    - (d) Mixing instructions including order of mixing, mixing temperatures, and other valid instructions, such as duration of mixing.
    - (e) Assigned beyond-use date.
    - (f) Container used in dispensing.
    - (g) Storage requirements.
    - (h) Any quality control procedures.
  - (5) Compounding record documents the actual ingredients in the preparation and the person responsible for the compounding activity and includes:
    - (a) Name and strength of the compounded preparation.
    - (b) The formulation record reference.
    - (c) Sources and lot numbers of the ingredients.
    - (d) Total number of dosage units compounded.
    - (e) Name of compounding personnel who prepared the preparation.
    - (f) The date of preparation.
    - (g) The assigned internal identification number, lot number, and prescription numbers.

- (h) Assigned beyond-use date.
    - (i) Results of all quality control procedures.
  - (6) Temperature log records the daily monitoring of temperatures in the storage area specifically for the controlled room temperature, refrigerator, freezer, or incubator.
- 3. Nonsterile compounding. Compounders are to use the following steps to minimize error and maximize the prescriber's intent, specifics can be found in pharmaceutical compounding - nonsterile compounding (USP 795):
  - a. Judge the suitability of the prescription of the preparation in terms of safety and intended use.
  - b. Perform necessary calculations to establish the amounts of ingredients needed.
  - c. Identify equipment and utensils needed.
  - d. Don the proper attire and properly wash hands and arms.
  - e. Clean the compounding area and needed equipment.
  - f. Only one prescription can be compounded at a time in the specified compounding area.
  - g. Assess weight variation, adequacy of mixing, clarity, odor, color consistency, and pH as appropriate of the completed preparation.
  - h. Annotate the compounding and formulation records.
  - i. Label the prescription containers appropriately.
  - j. Sign and date the prescription or compounding record affirming that all procedures were carried out to ensure uniformity, identity, strength, quantity, and purity.
  - k. Thoroughly clean all equipment immediately when finished.
- 4. Compounding process for compounded sterile preparations. Compounders are to follow the USP chapter 797 standards and use the following steps to minimize error and maximize the prescriber's intent:
  - a. Judge the suitability of the prescription for the compounded sterile preparation in terms of safety and intended use.
  - b. Perform necessary calculations to establish the amounts of ingredients needed.
  - c. Identify equipment and utensils needed for the preparation of the compounded sterile preparation.
  - d. Sterile compounding areas and critical areas must be structurally isolated from other areas designated to avoid unnecessary traffic and airflow disturbances according to USP chapter 797, separate from nonsterile compounding areas, and restricted to qualified compounding personnel.
  - e. Policies and procedures must be established in accordance with USP chapter 797 for personnel cleaning and garbing for protection and avoidance of containment.
  - f. Clean and sanitize the compounding area and needed equipment according to USP chapter 797.

5. Facilities for sterile compounding should conform with USP chapter 797.
6. Equipment specific for sterile compounding should conform with USP chapter 797.
7. Poison record book and suitable prescription files.
8. Suitable current reference sources either in book or electronic data form (available in the pharmacy or online) which might include the United States Pharmacopeia and National Formulary, the United States Pharmacopeia Dispensing Information, Facts & Comparisons, Micro Medex, the ASHP Formulary, [Clinical Pharmacology](#), or other suitable references determined by the board which are pertinent to the practice carried on in the licensed pharmacy.
9. Compounding for office use.
  - a. It is acceptable to compound human drug products to be used by North Dakota practitioners in their office for administration to patients provided they are prepared by a facility licensed as an outsourcing facility in accordance to North Dakota Century Code section 43-15.3-13 or by a resident North Dakota pharmacy.
  - b. It is acceptable for any licensed pharmacy to compound veterinary drug products to be used by veterinarians in their office for administration to client's animals. These compounded office use products may be dispensed to clients for use in a single treatment episode, not to exceed a one hundred twenty-hour supply.
  - c. Sales to other pharmacies, veterinarians, clinics, or hospitals are manufacturing and are not allowed. It is the responsibility of the pharmacy and pharmacist involved in the compounding to ensure compliance with this section for the products they compound.
10. ~~Hazardous~~ [Compounding of hazardous](#) drugs ~~as compounded sterile products (CSPs)~~.
  - a. Hazardous drugs, ~~when prepared for administration only~~, shall be prepared under conditions that protect the health care worker and other personnel in the preparation and storage areas [according to USP chapter 800](#). Appropriate personnel protective equipment shall be worn when compounding hazardous drugs [according to USP chapter 800](#).
  - b. Hazardous drugs shall be stored and prepared separately from other nonhazardous drugs in a manner to prevent contamination and personnel exposure [according to USP chapter 800](#).
  - c. Hazardous drugs shall be handled ~~with caution at all times using appropriate chemotherapy gloves during receiving, distribution, stocking, inventorying, preparation for administration, and disposal~~.
  - ~~d. Hazardous drugs shall be prepared in an ISO class 5 environment with protective engineering controls in place and following aseptic practices specified for the appropriate contamination risk levels specified in this chapter.~~
  - ~~e. All hazardous drugs shall be prepared in a biological safety cabinet (BSC) or a compounding aseptic containment isolator (CACI). The BSC or CACI shall be placed in an ISO class 7 area that is physically separated (i.e., a different area from other preparation areas) and with negative pressure to adjacent positive pressure ISO class 7 or better anterooms. If the CACI is used outside of a buffer area, the compounding area shall maintain a minimum negative pressure of 0.03 inch water column and have a minimum of twelve air changes per hour~~ [by the pharmacy according to USP chapter 800](#).

~~f.d.~~ All personnel who compound hazardous drugs shall be fully trained in the storage, handling, and disposal of these drugs. ~~This training shall occur prior to preparing or handling hazardous drugs and this training shall be by testing specific hazardous drug-handling techniques. Such training shall be documented for each person at least annually~~ according to USP chapter 800.

~~The state board of pharmacy recognizes that the equipment needed will depend on the type of pharmaceutical services offered, and therefore, variations for required equipment may be granted by the state board of pharmacy.~~

**History:** Amended effective August 1, 1983; April 1, 1988; October 1, 1999; December 1, 2003; April 1, 2012; April 1, 2017; December 1, 2019.

**General Authority:** NDCC 28-32-02, 43-15-10(9), 43-15-10(12), 43-15-10(14), 43-15-35(2), 43-15-35(3), 43-15-36

**Law Implemented:** NDCC 28-32-03, 43-15-10(9), 43-15-10(12), 43-15-10(14), 43-15-35(2), 43-15-35(3), 43-15-36

## CHAPTER 61-02-02

### 61-02-02-01. Building standards for pharmacies.

Any new pharmacy, or any existing pharmacy which is being remodeled, except in the cases of institutional practice, must comply with the following provisions:

1. **Approval of plans.** The prescription area, merchandising area, waiting area, storeroom, restroom, and all partitions, doors, windows, and fixtures shall be indicated on floor plans showing appropriate elevations submitted to the board at the time the application for a new pharmacy is filed, or prior to remodeling. Such plans shall be submitted to the board prior to proceeding with the new construction. Before a pharmacy permit is issued, the plans submitted must meet the approval of the board.
2. **Minimum size of the prescription area.** The minimum size of the prescription area, including adjacent patient consultation and information area and drug storage areas shall be not less than one thousand square feet [92.90 square meters], with an additional two hundred fifty square feet [23.23 square meters], to be used but not restricted to prescription receiving, checkout, and entrance area, but in all cases shall be large enough to carry out efficiently the elements of the practice of pharmacy at the level of activity of that operation. All of the allotted square footage space, including adequate shelving, shall lend itself to efficient pharmaceutical practice so as to permit free movement and visual surveillance. A patient consultation and information center must be provided. This patient consultation and information center may not be located in the prescription area or drug storage area. The patient consultation and information center must afford the patient privacy from visual or auditory detection or surveillance by any unauthorized person or persons. The patient consultation and information center must be accessible by a patient by provision of an entrance and exit that does not require the patient to enter or traverse the prescription area or drug storage areas.
3. **Prescription compounding counter.** There shall be a prescription compounding counter which shall provide a minimum of sixteen square feet [1.49 square meters] of unobstructed working space for one pharmacist, and a minimum of twenty-four square feet [2.23 square meters] of unobstructed working space where two or more pharmacists are on duty at any one time.

The floor area to be occupied by the dispensing pharmacists shall extend the full length of the prescription compounding counter, and shall be clear and unobstructed for a minimum distance of thirty inches [76.2 centimeters] from the counter.

4. **Prescription area.** The prescription area shall be separated from other areas in such a manner that prescription or nonproprietary drugs or devices are inaccessible to the reach of any unauthorized person.
5. **Light and ventilation.** The prescription area and all storerooms shall be well-lighted, ventilated, and kept free of obnoxious odors.
6. **Refrigerator.** ~~The restricted area shall contain a refrigerator for its exclusive use.~~ **Storage of medications.** Systems at pharmacy location must ensure medications are stored within the manufacture-recommended temperatures.
  - a. Room temperature in the drug storage must be monitored to ensure variations are limited.
  - b. When medications are stored in a refrigerator or freezer, the pharmacy shall use a continuous temperature monitoring device that reports excursions that may occur from accepted temperature levels. Units must exclusively be used for medications.

7. **Change in location of a pharmacy.** Before a licensed pharmacy changes the location of its business, or its physical dimensions or elements of physical security, it shall first submit the changes to the board for its approval that the changes do conform with all rules of the board.
8. **Storage of other merchandise - Telephone.** The prescription department shall not be used for storage of merchandise other than that used in the preparation or dispensing of medical needs. If such stored material is present, such area shall not be included as part of the prescription department. A telephone shall be immediately accessible in the prescription area, and the telephone number shall coincide with the telephone number on prescription labels.
9. **Building standards variations.** The board of pharmacy recognizes that the building standards for pharmacies will depend on the type of pharmaceutical services offered, and therefore, variations for required building standards may be granted by the board of pharmacy.
10. **Remodeling or improvement variations.** When the pharmacy is remodeling within existing permitted space or when a pharmacy is attempting to improve toward the standards in section 61-02-02-01 or chapters 61-02-03 or 61-02-04, the board may grant approval to move toward the standards even though the amount of space available does not allow complete compliance with the standards.

**History:** Amended effective August 1, 1983; April 1, 1988; June 1, 1992; January 1, 2003; [October 1, 2019](#).

**General Authority:** NDCC 28-32-02, 43-15-10(9), 43-15-10(11), 43-15-10(12), 43-15-10(14)

**Law Implemented:** NDCC 28-32-03, 43-15-01(16), 43-15-10(9), 43-15-10(11), 43-15-10(12), 43-15-10(14)

## CHAPTER 61-02-06

### 61-02-06-02. Requirements for storage and retrieval of prescription information.

Electronic data processing equipment or media, when used to store or process prescription information, shall meet the following requirements:

1. Must guarantee the confidentiality of the information contained in the database. Must require that the transmission of electronic prescriptions from prescriber to pharmacist not be compromised by interventions, control, or manipulation of said prescriptions by any other party.
2. An electronic system must provide online retrieval via computer screen or hard-copy printout of original prescription order information for those prescription orders which are currently authorized for refilling. If more refills are authorized, it must be noted on the computer screen or on the hard copy of the prescription or a new prescription must be produced.
3. Must be able to produce a hard-copy daily summary of controlled substance transactions. Monthly summaries must be produced and filed with the biennial inventory or electronic system must allow tracking of adjustments and changes made to controlled substance transactions.
4. Be capable of recording and carrying in the record all dates of refills of any prescription and the initials of the pharmacist.
5. Be capable of producing a patient profile indicating all drugs being taken and the date of refills of these prescriptions, as required by North Dakota Century Code section 43-15-31.1.
6. Be capable of reconstructing information, by daily backups in the event of a computer malfunction or accident resulting in destruction of the database.

**History:** Effective August 1, 1983; amended effective July 1, 1990; December 1, 1996; July 1, 2011; October 1, 2019.

**General Authority:** NDCC 28-32-02, 43-15-10(9)(12)(14)

**Law Implemented:** NDCC 43-15-10(9)(12)(14)

## CHAPTER 61-02-07.1

### 61-02-07.1-03. Educational preparation.

1. To be eligible to be registered by the board of pharmacy as a pharmacy technician the person must have completed one of the following requirements:
  - a. Successful completion of an American society of health systems pharmacists accredited academic program;
  - b. An American society of health systems pharmacists accredited on-the-job training program.
2. Technician certification:
  - a. An applicant for registration as a pharmacy technician must have obtained certification by a national certification body approved by the board of pharmacy.
  - b. A technician registered after August 1, 1995, must obtain ~~and maintain~~ certification by a national certification body approved by the board of pharmacy.
  - c. ~~A registered technician who does not hold certification on April 1, 2011, will have until March 1, 2014, to obtain that certification.~~
  - ~~d. A copy of a current certification certificate will serve as proof of the technician's continuing education requirement upon renewal or a continuing education audit.~~
  - ~~e. The pharmacy technician certification board is an and national healthcareer association are approved certification body~~bodies~~.~~
  - d. If a competency examination is developed by the national association of boards of pharmacy to foster transfer of registration between states, this will be accepted in lieu of certification.

**History:** Effective October 1, 1993; amended effective October 1, 2012; October 1, 2019.

**General Authority:** NDCC 28-32-02, 43-15-10(12)(14)(19)

**Law Implemented:** NDCC 43-15-10(12)(14)(19)

### 61-02-07.1-04. Ratio of pharmacists to pharmacy technicians.

The ratio of pharmacists to pharmacy technicians may not be greater than one to ~~three~~four (one pharmacist to ~~three~~four pharmacy technicians) in a retail and hospital setting. The ratio of pharmacists to pharmacy technicians may not be greater than one to ~~four~~five (one pharmacist to ~~four~~five pharmacy technicians) in a ~~hospital or~~ closed-door pharmacy that does not deal directly with patients. ~~A pharmacist may not supervise more than four telepharmacy sites.~~ This ratio does not include other supportive personnel or interns.

**History:** Effective October 1, 1993; amended effective January 1, 2005; October 1, 2019.

**General Authority:** NDCC 28-32-02, 43-15-10(12)(14)

**Law Implemented:** NDCC 28-32-03, 43-15-10(12)(14)

### 61-02-07.1-10. Pharmacy technician continuing education.

1. Each pharmacy technician shall complete at least ten hours of approved pharmacy technician continuing education every year as a condition of renewal of a registration as a pharmacy technician in North Dakota.



2. There may be no carryover or extension of continuing education units with the exception that continuing education units obtained twelve months prior to the beginning of each annual reporting period may be used in the current annual reporting period which begins March first of each year and ends the last day of February, or the previous reporting period. However, they may not be counted as credit in both reporting periods. The failure to obtain the required ten hours of continuing education by the renewal date may result in a suspension for a minimum of thirty days, or a maximum of the period ending the date the continuing education is completed.
3. Pharmacy technicians shall maintain their own records ~~on forms supplied by the board~~. The records must be maintained for a two-year period.
4. The requirements of this section do not apply to a pharmacy technician applying for a first renewal of a registration.
5. A pharmacy technician registered with the board may make application to the board for a waiver of compliance with the pharmacy technician continuing education requirements and may be granted an exemption by the board.
6. Upon request of the board, proof of compliance must be furnished to the board.

~~7. Approved pharmacy technician continuing education means those pharmacy technician continuing education programs approved by the board. The board shall maintain a record of approved programs, including the hours of credit assigned to each program which shall be available upon request.~~

**History:** Effective July 1, 1996; amended effective January 1, 2005; January 1, 2010; [October 1, 2019](#).

**General Authority:** NDCC 28-32-02, 43-15-10(12)(14)(19)

**Law Implemented:** NDCC 28-32-03

## CHAPTER 61-03-02

### 61-03-02-04. Distribution and control.

1. General. The consulting pharmacist shall establish written procedures for the safe and efficient distribution of pharmaceutical products; which shall be on hand for inspections.
2. Responsibility of consulting pharmacist. The consulting pharmacist shall be responsible for the safe and efficient distribution of, control of, and accountability of medications by developing procedures subject to the approval of the pharmaceutical services committee of the long-term care facility, to include:
  - a. Establishment of specifications for the storage, distribution, and procurement of medications and biologicals.
  - b. Participation in those aspects of the long-term care patient evaluation program which relate to drug utilization and effectiveness.
  - c. Providing information on a twenty-four-hour basis for assistance in emergency situations.
  - d. Assuring all medication shall be stored in a locked area or locked cart.
  - e. Review, evaluate, and make recommendations monthly regarding drug utilization to the pharmaceutical services committee.
  - f. Minimum standards that all provider pharmacists must meet to include the following:
    - (1) Expected delivery times for new orders and reorders.
    - (2) Procedures to ensure accountability during delivery.
    - (3) Methods to document receipt of medications by the facility.
    - (4) Procedure to obtain emergency medications and for the provider pharmacist to receive orders.
    - (5) Procedures used by the facility to reorder medications and for the provider pharmacist to receive reorders.
    - (6) Expected scope of services and medications to be provided by the provider pharmacist. If the provider pharmacist cannot provide the complete scope of services and medications, the provider pharmacist shall designate alternative sources.
  - g. Procedures that allow for use of or repackaging of medications received which are not in the packaging system used by the facility.
  - h. Policy that is included as a part of the patient admissions packet that describes the responsibility of the patient or provider pharmacist to compensate a secondary pharmacist for medications or packaging services that the provider pharmacist chosen by the patient is either unwilling or unable to provide.
3. Responsibility of provider pharmacist. All provider pharmacists shall meet the minimum standards established by the consulting pharmacist.
4. Discontinued drugs.

- a. The consulting pharmacist shall develop and implement policies and procedures to ensure that all discontinued or outdated drugs or containers with worn, illegible or missing labels are destroyed or disposed of so as to render them unusable. ~~Controlled drugs shall be destroyed by the consulting pharmacist subject to guidelines and approval of the state board of pharmacy.~~
  - b. Controlled drugs shall be destroyed at the specific institution nursing facility according to policies and procedures set by the consultant pharmacist. Destruction must render the medication nonretrievable. Destruction must be witnessed and documented on a log by a combination of at least two licensed staff members or pharmacists.
  - c. Noncontrolled drugs may be destroyed at the institution according to policies and procedures set by the consultant pharmacist or returned to the provider pharmacy, for possible credit or destruction. ~~A log must be made when the drugs are discontinued. If drugs are destroyed at the institution, two professionals must sign the destruction log.~~
5. Practitioner's orders. A pharmacist shall review the medication order, or a copy thereof.
- a. Authorization. Any licensed practitioner authorized by law to prescribe drugs within the scope of the practitioner's license may prescribe for the practitioner's patient in a long-term facility.
  - b. Abbreviations. Orders employing abbreviations or chemical symbols will be only those which are customarily used in the practice of medicine and pharmacy or those on a list of approved abbreviations developed by the pharmaceutical services committee of the facility.
  - c. Requirements. Orders for drugs for use by patients of the facility shall, at a minimum, contain patient name, drug name and strength, directions for use, date of order, and name of prescriber. On the facility reorder form, include all of the above except for directions.
  - d. Emergency medication order. In cases where an emergency medication order is written when pharmacy services are unavailable, the medication order shall be reviewed by the pharmacist as soon as reasonably possible.
  - e. Verification. Verification of the accuracy of any medication dispensed and of any transcriptions made of that order shall be done by handwritten initials of the pharmacist so certifying.
  - f. Duration. The prescribed medications should be for a specific time.
6. An automated dispensing system is authorized for use in long-term care facilities to store controlled bulk drugs.
- a. Drugs in the automated dispensing system are not considered dispensed until taken out by authorized personnel at the long-term care facility, once released by the pharmacy pursuant to a prescription.
  - b. Only single doses may be removed from the automated dispensing system at one time.
  - c. The pharmacy must have a separate drug enforcement administration number for the automated dispensing system at each location.
  - d. All records of dispensing must be kept at the central pharmacy.

- e. The automated dispensing system shall permit access to only one controlled substance at each authorized entry.
  - f. Only retail pharmacies are authorized to use an automated dispensing system.
  - g. Pharmacies cannot share an automated dispensing system at a long-term care facility.
  - h. North Dakota controlled substance registration is required.
7. Controlled drug accountability. The consulting pharmacist shall establish and implement effective procedures and assure that adequate records be maintained regarding use and accountability of controlled substances which meet federal and state laws and regulations, and which shall at least specify the following:
- a. Name of drug.
  - b. Dose.
  - c. Prescriber.
  - d. Patient.
  - e. Date and time of administration.
  - f. Person administering the drug.
8. Recall. The consulting pharmacist shall develop and implement a recall procedure that can readily be activated to assure the medical staff of the facility, the provider pharmacy, and the consulting pharmacist that all drugs included in the recall, located within the facility, are returned to the provider pharmacy for proper disposition.
9. Records and reports. The consulting pharmacist shall supervise the maintenance of such records and reports as are required to ensure patient health, safety, and welfare and, at a minimum, the following:
- a. Pharmacy patient profiles and medication administration records.
  - b. Reports of suspected adverse drug reactions.
  - c. Inspections of drug storage areas.
  - d. Controlled drug and accountability reports, including board of pharmacy destroyed medication forms for controlled and noncontrolled medications.
  - e. Such other and further records and reports as may be required by law and this chapter.
10. Labeling.
- a. All stock drugs intended for use within the facility shall be in appropriate containers and adequately labeled as to identify at a minimum: brand name or generic name and manufacturer, and strength. An internal code which centrally references manufacturer and lot number can be utilized.
  - b. Whenever any drugs are added to parenteral solutions, whether within or outside the direct and personal supervision of a pharmacist, such admixtures shall be labeled with a distinctive supplementary label indicating the name and amount of the drug added, date and time of addition, expiration date, administration time and infusion rate when applicable, and name or initials of person so adding. This excludes any single dose medication prepared and totally administered immediately.

**History:** Effective August 1, 1983; amended effective October 1, 1999; December 1, 2003; October 1, 2007; [October 1, 2019](#).

**General Authority:** NDCC 28-32-02, 43-15-10(12), 43-15-10(14)

**Law Implemented:** NDCC 28-32-02, 43-15-10(12), 43-15-10(14)

## CHAPTER 61-03-03.1

### 61-03-03.1-01. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Approved pharmacy experiential program" means structured courses in the pharmacy professional curriculum that are administered by a college of pharmacy, and approved by the state board of pharmacy, via accreditation by the American council on pharmaceutical education.
2. "Approved pharmacy intern program" means pharmacy practice in a board-approved experiential program after a student has been accepted into a board-approved accredited college or school of pharmacy. The entire one thousand five hundred hours of credit shall be included in the four-year doctor of pharmacy program as an intern.
3. "Hour" means the standard sixty minutes division of time.
4. "Intern" means a person licensed by the state board of pharmacy for the purpose of receiving instruction in the practice of pharmacy from a preceptor. The state board of pharmacy may license as an intern any candidate who has graduated from high school or obtained a GED and successfully completed no less than one academic year of full-time college or university enrollment directed towards the prepharmacy requirements with a consistently declared intent to seek admission to an accredited doctor of pharmacy program and has satisfied the state board of pharmacy that the candidate is of good moral character or as required when a student has been unconditionally accepted into the doctor of pharmacy program.
5. "Location" means any establishment other than a preceptor pharmacy approved by the state board of pharmacy.
6. "Preceptor" means an educator and a licensed pharmacist in good standing with the state board of pharmacy who will devote sufficient time to educate a student in the practice of pharmacy as described in subsection 22 of North Dakota Century Code section 43-15-01.
7. "Preceptor pharmacy" means the pharmacy where the preceptor is practicing the profession. This pharmacy must have a clear record with respect to adherence to federal, state, and municipal laws governing any phase of activity in which it is engaged and must be licensed by the state board of pharmacy, or other duly authorized licensing agency, where located and must have a private patient consultation area.
8. "Supervision" means that in the approved preceptor pharmacy or other location where the intern is being taught, a licensed pharmacist designated as preceptor or another licensed pharmacist shall be in continuous contact with and actually giving instructions to the intern during all professional activities.

**History:** Effective October 1, 1999; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02, 43-15-10

**Law Implemented:** NDCC 28-32-02, 43-15-10, 43-15-18

**CHAPTER 61-03-04**  
**CONTINUING PHARMACEUTICAL EDUCATION**

Section

61-03-04-01	Definitions
61-03-04-02	Requirements for Continuing Pharmaceutical Education
61-03-04-03	Approved Continuing Education
61-03-04-04	Advisory Council on Continuing Pharmaceutical Education <u>[Repealed]</u>

**61-03-04-02. Requirements for continuing pharmaceutical education.**

1. Each pharmacist shall complete at least fifteen hours (1.5 c.e.u.) of approved continuing pharmaceutical education every year as a condition of renewal of a certificate of licensure as a pharmacist in the state of North Dakota.
2. There may be no carryover or extension of continuing education units with the exception that continuing education units obtained twelve months prior to the beginning of each annual reporting period which begins March first of each year and ends the last day of February, may be used in the current annual reporting period or the previous reporting period. However, they may not be counted as credit in both reporting periods. The failure to obtain the required fifteen hours of continuing education by the renewal date may result in a suspension for the minimum of thirty days or a maximum of the period ending the date the continuing education is completed.
3. Pharmacists shall maintain their own records ~~on forms supplied by the board~~. The records shall be maintained for a two-year period.
4. The requirements of this section do not apply to a pharmacist applying for a first renewal of a certificate of licensure.
5. A pharmacist holding a certificate of licensure from the board may make application to the board for a waiver of compliance with the continuing pharmaceutical education requirements and may be granted an exemption by the board. No pharmacist holding such an exemption may practice pharmacy in North Dakota until reinstated by the board after completing fifteen hours of continuing pharmaceutical education (one and one-half c.e.u.) during the year before reinstatement.
6. Upon request of the board, proof of compliance must be furnished to the board.

**History:** Effective April 1, 1986; amended effective January 1, 2005; January 1, 2010; October 1, 2019.

**General Authority:** NDCC 28-32-02, 43-15-10(12)(14), 43-15-25.1

**Law Implemented:** NDCC 28-32-03, 43-15-10(12)(14), 43-15-25.1

**61-03-04-04. Advisory council on continuing pharmaceutical education.**

Repealed effective October 1, 2019.

- ~~1. There is hereby established an advisory council to the state board of pharmacy consisting of:~~
- ~~a. Two pharmacists appointed by the state board of pharmacy.~~
  - ~~b. Two pharmacists appointed by the North Dakota state university college of pharmacy.~~
  - ~~c. Two pharmacists appointed by the North Dakota state pharmaceutical association.~~

- ~~2. The advisory council on continuing pharmaceutical education shall advise the state board of pharmacy in the implementation, coordination, and accreditation of programs of continuing pharmaceutical education and members shall serve without compensation.~~
- ~~3. The advisory council on continuing pharmaceutical education shall meet at least annually, and at such other times as determined by the council. The advisory council shall annually elect a chairman and vice chairman from its membership, and the secretary of the state board of pharmacy shall act as secretary to the council.~~
- ~~4. Membership of each pharmacist on the advisory council on continuing pharmaceutical education shall be for a two-year term, with one of the two pharmacists appointed by the state board of pharmacy, North Dakota state university college of pharmacy, and the North Dakota state pharmaceutical association, to have a term of one year upon the initial appointment of pharmacists to the advisory council, and thereafter shall have a two-year term. The purpose of this requirement is to stagger the membership so that not all members will be replaced at the end of each two-year period.~~

**History:** Effective April 1, 1986.

**General Authority:** NDCC 28-32-02, 43-15-10(12)(14), 43-15-25.1

**Law Implemented:** NDCC 28-32-03, 43-15-10(12)(14), 43-15-25.1



## CHAPTER 61-04-03

### 61-04-03-01. Destruction of controlled substances.

Pharmacists and pharmacies are ~~prohibited from destruction of~~allowed to destroy controlled substances as defined in subsection ~~46~~ of North Dakota Century Code section 19-03.1-01. Destruction of a pharmacy's controlled substance inventory must be done consistent with standards set by the drug enforcement administration and must be documented on a drug enforcement administration form 41. The drug enforcement administration form 41 should be kept at the pharmacy with controlled substance records and must be made available to the state board upon request. Destruction of controlled substances is permitted ~~and shall be limited to~~ be completed by the executive ~~secretary~~director of the board, ~~or~~ a compliance officer of the board, or any one member of the board. ~~A board member may not destroy controlled substances within a pharmacy in which the member is employed, has an ownership interest, or is the pharmacist in charge.~~

**History:** Effective April 1, 1988; amended effective October 1, 2019.

**General Authority:** NDCC 28-32-02, 43-15-10(12), 43-15-10(14)

**Law Implemented:** NDCC 28-32-03, 43-15-10(12), 43-15-10(14)

## CHAPTER 61-08-01

### 61-08-01-08. Administrative inspection.

North Dakota pharmacy inspectors may conduct onsite periodic routine inspections during reasonable business hours of out-of-state pharmacies registered to do business in North Dakota. Alternatively, the North Dakota board of pharmacy may contract with the respective out-of-state regulatory authorities to conduct and perfect periodic routine inspections.

1. To obtain a license as a nonresident pharmacy, an applicant shall:
  - a. Have submitted an application form prescribed by the board as required under section 61-08-01-02; and
  - b. Have paid the fees specified by the board for the issuance of the license as specified in article 61-11.
2. The pharmacy owner, if an individual, and principals and owners who directly or indirectly own greater than ten percent interest in the company, if the company is not publically held, shall have undergone a state and federal fingerprint-based criminal background check ~~as specified~~ upon request by the board.
3. The facility shall be inspected in a manner and frequency prescribed by the board:
  - a. For nonresident pharmacies that prepare and ship sterile or nonsterile compounded products, or sterile and nonsterile compounded products into this state, the facility must be inspected at least once every ~~twelve~~ twenty-four months by:
    - (1) The board or its duly authorized agent; or
    - (2) A duly authorized agent of a third party approved by the board which is the national association of boards of pharmacy verified pharmacy program.
  - b. For nonresident pharmacies that do not ship sterile and nonsterile compounded products into this state, the facility must be inspected at least once every two years by:
    - (1) The resident state board of pharmacy, if the resident board's inspection is substantially equivalent to the inspection in this state;
    - (2) The board or its duly authorized agent; or
    - (3) A duly authorized agent of a third party approved by the board, which is the national association of boards of pharmacy verified pharmacy program.
  - c. Nonresident pharmacies that dispense more than twenty-five percent of the pharmacy's total prescription volume as a result of original prescriptions or refills solicited through the internet, must be ~~accredited~~ inspected by:
    - ~~(1) The the national association of boards of pharmacy verified ~~internet~~ pharmacy practice sites program; or~~
    - ~~(2) The national association of boards of pharmacy veterinary verified internet pharmacy practice sites program.~~
  - d. Costs for inspections conducted by the board or an approved third party will be paid by the applicant.
4. At the time of renewal, the nonresident pharmacy shall:

- a. Submit an application form prescribed by the board;
- b. Provide proof of a recent inspection as outlined in subsection 3; and
- c. Submit the national association of boards of pharmacy e-profile identification (NABP e-Profile ID) of the pharmacy and pharmacist-in-charge.

~~5. The board may waive the requirement for a separate criminal background check in subsection 2. If the nonresident pharmacy is a current participant in a pharmacy verification program that provides complete and accurate owner criminal background screening and licensure, disciplinary, and inspection information to the state board of pharmacy, this requirement may also be waived.~~

~~6. Any new applicant or renewal application received after July 1, 2015, shall hold the required accreditation from the national association of boards of pharmacy.~~

**History:** Effective April 1, 1988; amended effective January 1, 2005; October 1, 2014; [October 1, 2019](#).

**General Authority:** NDCC 28-32-02, 43-15-10(7)(8)(9)(12)(14), 43-15-34, 43-15-35, 43-15-36, 43-15-38

**Law Implemented:** NDCC 28-32-02, 43-15-10(7)(8)(9)(12)(14), 43-15-34, 43-15-35, 43-15-36, 43-15-38

#### **61-08-01-09. Records.**

Prescription records documenting prescriptions dispensed and distributed to North Dakota consumers must be readily retrievable and available for board review. ~~North Dakota prescription orders, when initially dispensed, must be separated or readily retrievable or stamped in the lower left hand corner of the order form face with a one-inch [25.40-millimeters] green letter "ND" or separate prescription files~~ [upon request](#).

**History:** Effective April 1, 1988; [amended effective October 1, 2019](#).

**General Authority:** NDCC 28-32-02, 43-15-10(7)(8)(9)(12)(14), 43-15-34, 43-15-35, 43-15-36, 43-15-38

**Law Implemented:** NDCC 28-32-02, 43-15-10(7)(8)(9)(12)(14), 43-15-34, 43-15-35, 43-15-36, 43-15-38

## CHAPTER 61-12-01

### 61-12-01-03. Operation of program.

1. The board may charge a fee to an individual who requests the individual's own information from the central repository.
2. The board may charge a fee to a person who requests statistical, aggregate, or other de-identified information.
3. The board may allow access to controlled substance records to delegates certified by an authorized individual listed in North Dakota Century Code section 19-03.5-03. The authorized individual shall manage the delegates accessing the repository under their authority.
4. The board shall allow access to controlled substance records to authorized individuals listed in North Dakota Century Code section 19-03.5-03 for a period of three years.

**History:** Effective December 1, 2006; amended effective October 1, 2019.

**General Authority:** NDCC 19-03.5

**Law Implemented:** NDCC 19-03.5

### 61-12-01-04. Required use for certain dispensing situations.

1. ~~Prior to dispensing a prescription, each~~ Each dispenser licensed by a regulatory agency in the state of North Dakota who dispenses a controlled substance to a patient, ~~for the treatment of pain or anxiety~~ shall, at a minimum, request and review a prescription drug monitoring report covering at least a one-year time period or another state's report, or both reports, when applicable and available; prior to initially dispensing a prescription, with the exception of prescriptions for a patient in a skilled long-term care facility or a hospice patient. Further reports must be requested and reviewed if the dispenser becomes aware of a person currently:
  - a. Receiving reported drugs from multiple prescribers;
  - b. Receiving reported drugs for more than twelve consecutive weeks;
  - c. Abusing or misusing reported drugs (i.e., over-utilization; early refills; appears overly sedated or intoxicated upon presenting a prescription for a reported drug; or an unfamiliar patient requesting a reported drug by specific name, street name, color, or identifying marks);
  - d. Requesting the dispensing of a reported drug from a prescription issued by a prescriber with whom the dispenser is unfamiliar (i.e., the prescriber is located out-of-state or the prescriber is outside the usual pharmacy geographic prescriber care area); or
  - e. Presenting a prescription for reported drugs when the patient resides outside the usual pharmacy geographic patient population.
2. After obtaining an initial prescription drug monitoring report on a patient, a dispenser shall use professional judgment based on prevailing standards of practice in deciding the frequency of requesting and reviewing further prescription drug monitoring reports or other state's reports, or both reports, for that patient.
3. In the rare event a report is not immediately available, the dispenser shall use professional judgment in determining whether it is appropriate and in the patient's best interest to dispense the prescription prior to receiving and reviewing a report.

4. For the purpose of compliance with subsection 1, a report could be obtained through a prescription drug monitoring program intergration with software or also a board-approved aggregate tool, for which the ~~NARxCHECK~~NARxCARE will be an approved tool. ~~The national association of boards of pharmacy foundation's NARxCHECK service is a risk assessment tool for health care providers and pharmacists that accesses patient prescription information from prescription drug monitoring databases, analyzes the data, and provides a risk-based score that includes prescription drug monitoring program data and graphical analysis to assist in prescribing and dispensing decisions.~~

**History:** Effective October 1, 2014; amended effective October 1, 2019.

**General Authority:** NDCC 19-03.5, 19-03.5-09, 43-15-10(12)

**Law Implemented:** NDCC 19-03.5

## CHAPTER 61-13-01

### 61-13-01-03. Scheduling.

- ~~1. The following substances are hereby placed in schedule I of the Controlled Substances Act, North Dakota Century Code section 19-03.1-05, schedule I, subsection 5, hallucinogenic substances:~~
  - ~~a. CP 47,497 and homologues 2-[(1R,3S)-hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol.~~
  - ~~b. HU-210[(6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[*c*]chromen-1-ol].~~
  - ~~c. HU-211 (dexanabinol, (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[*c*]chromen-1-ol).~~
  - ~~d. JWH-018 1-Pentyl-3-(1-naphthoyl)indole.~~
  - ~~e. JWH-073 1-Butyl-3-(1-naphthoyl)indole.~~
  - ~~f. Cannabinoids, synthetic: it includes the chemicals and chemical groups listed below, including their homologues, salts, isomers, and salts of isomers. The term "isomer" includes the optical, position, and geometric isomers.~~
    - ~~(1) Naphthoylindoles. Any compound containing a 3-(1-naphthoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl, 1-(N-methyl-3-morpholinyl)methyl, or (tetrahydropyran-4-yl)methyl group, whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent.~~
    - ~~(2) Naphthylmethylindoles. Any compound containing a 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl, 1-(N-methyl-3-morpholinyl)methyl, or (tetrahydropyran-4-yl)methyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the naphthyl ring to any extent.~~
    - ~~(3) Naphthoylpyrroles. Any compound containing a 3-(1-naphthoyl)pyrrole structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl, 1-(N-methyl-3-morpholinyl)methyl, or (tetrahydropyran-4-yl)methyl group whether or not further substituted in the pyrrole ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples include: (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone. Other names: JWH-307~~
    - ~~(4) Naphthylmethylindenes. Any compound containing a naphthylideneindene structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl, 1-(N-methyl-3-morpholinyl)methyl, or (tetrahydropyran-4-yl)methyl group whether or not further substituted in the indene~~

ring to any extent, whether or not substituted in the naphthyl ring to any extent. Examples include: E-1-[1-(1-Naphthalenylmethylene)-1H-inden-3-yl]pentane  
Other names: JWH-176.

- (5) Phenylacetylindoles. Any compound containing a 3-phenylacetylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl, 1-(N-methyl-3-morpholinyl)methyl, or (tetrahydropyran-4-yl)methyl group whether or not further substituted in the indole ring to any extent, whether or not substituted in the phenyl ring to any extent.
- (6) Cyclohexylphenols. Any compound containing a 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic ring by an alkyl, haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl, 1-(N-methyl-3-morpholinyl)methyl, or (tetrahydropyran-4-yl)methyl group whether or not substituted in the cyclohexyl ring to any extent.
- (7) Benzoylindoles. Any compound containing a 3-(benzoyl)indole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl, 1-(N-methyl-3-morpholinyl)methyl, or (tetrahydropyran-4-yl)methyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the phenyl ring to any extent.
- (8) Tetramethylcyclopropanoylindoles. Any compound containing a 3-tetramethylcyclopropanoylindole structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, cyanoalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl, 2-(4-morpholinyl)ethyl, 1-(N-methyl-2-pyrrolidinyl)methyl, 1-(N-methyl-3-morpholinyl)methyl, or (tetrahydropyran-4-yl)methyl group whether or not further substituted in the indole ring to any extent and whether or not substituted in the tetramethylcyclopropanoyl ring to any extent.
- (a) (1-Pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone - Other names: UR-144.
- (b) (1-(5-fluoropentyl)indol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone - Other names: XLR-11.
- (c) (1-(2-morpholin-4-ylethyl)-1H-indol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone - Other names: A-796,260.
- (9) Others specifically named:
- (a) 1-[(N-methylpiperidin-2-yl)methyl]-3-(adamant-1-yl)indole - Other names: AM-1248.
- (b) N-Adamantyl-1-pentyl-1H-indole-3-carboxamide - Other names: JWH-018-adamantyl-carboxamide.
- (c) N-Adamantyl-1-fluoropentylindole-3-carboxamide - Other names: STS-135.
- (d) N-Adamantyl-1-pentyl-1H-Indazole-3-carboxamide - Other names: AKB-48.

~~(e) 1-Pentyl-3-(1-adamantoyl)indole — Other names: AB-001 and JWH-018-adamantyl analog.~~

~~(f) Naphthalen-1-yl-(4-pentyloxynaphthalen-1-yl)methanone — Other names: GB-13.~~

~~g. Substituted phenethylamines. This includes any compound, unless specifically excepted, specifically named in this schedule, or listed under a different schedule, structurally derived from phenylethan-2-amine by substitution on the phenyl ring in any of the following ways, that is to say — by substitution with a fused methylenedioxy ring, fused furan ring, or a fused tetrahydrofuran ring; by substitution with two alkoxy groups; by substitution with one alkoxy and either one fused furan, tetrahydrofuran, or tetrahydropyran ring system; by substitution with two fused ring systems from any combination of the furan, tetrahydrofuran, or tetrahydropyran ring systems.~~

~~(1) Whether or not the compound is further modified in any of the following ways, that is to say:~~

~~(a) By substitution of phenyl ring by any halo, hydroxyl, alkyl, trifluoromethyl, alkoxy, or alkylthio groups, or~~

~~(b) By substitution at the 2-position by any alkyl groups, or~~

~~(c) By substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, hydroxybenzyl, or methoxybenzyl groups.~~

~~(2) Examples include:~~

~~(a) 2-(4-Chloro-2,5-dimethoxyphenyl)ethanamine (also known as 2C-G or 2,5-Dimethoxy-4-chlorophenethylamine).~~

~~(b) 2-(2,5-Dimethoxy-4-methylphenyl)ethanamine (also known as 2C-D or 2,5-Dimethoxy-4-methylphenethylamine).~~

~~(c) 2-(2,5-Dimethoxy-4-ethylphenyl)ethanamine (also known as 2C-E or 2,5-Dimethoxy-4-ethylphenethylamine).~~

~~(d) 2-(2,5-Dimethoxyphenyl)ethanamine (also known as 2C-H or 2,5-Dimethoxyphenethylamine).~~

~~(e) 2-(4-Iodo-2,5-dimethoxyphenyl)ethanamine (also known as 2C-I or 2,5-Dimethoxy-4-iodophenethylamine).~~

~~(f) 2-(2,5-Dimethoxy-4-nitro-phenyl)ethanamine (also known as 2C-N or 2,5-Dimethoxy-4-nitrophenethylamine).~~

~~(g) 2-(2,5-Dimethoxy-4-(n)-propylphenyl)ethanamine (also known as 2C-P or 2,5-Dimethoxy-4-propylphenethylamine).~~

~~(h) 2-[4-(Ethylthio)-2,5-dimethoxyphenyl]ethanamine (also known as 2C-T-2 or 2,5-Dimethoxy-4-ethylthiophenethylamine).~~

~~(i) 2-[4-(Isopropylthio)-2,5-dimethoxyphenyl]ethanamine (also known as 2C-T-4 or 2,5-Dimethoxy-4-isopropylthiophenethylamine).~~

~~(j) 2-(4-bromo-2,5-dimethoxyphenyl)ethanamine (also known as 2C-B or 2,5-Dimethoxy-4-bromophenethylamine).~~



~~(k) 2-(2,5-dimethoxy-4-(methylthio)phenyl)ethanamine (also known as 2C-T or 4-methylthio-2,5-dimethoxyphenethylamine).~~

~~(l) 1-(2,5-dimethoxy-4-iodophenyl)propan-2-amine (also known as DOI or 2,5-Dimethoxy-4-iodoamphetamine).~~

~~(m) 1-(4-Bromo-2,5-dimethoxyphenyl)-2-aminopropane (also known as DOB or 2,5-Dimethoxy-4-bromoamphetamine).~~

~~(n) 1-(4-chloro-2,5-dimethoxyphenyl)propan-2-amine (also known as DOC or 2,5-Dimethoxy-4-chloroamphetamine).~~

~~(o) 2-(4-bromo-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine (also known as 2C-B-NBOMe; 25B-NBOMe or 2,5-Dimethoxy-4-bromo-N-(2-methoxybenzyl)phenethylamine).~~

~~(p) 2-(4-iodo-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine (also known as 2C-I-NBOMe; 25I-NBOMe or 2,5-Dimethoxy-4-iodo-N-(2-methoxybenzyl)phenethylamine).~~

~~(q) N-(2-Methoxybenzyl)-2-(3,4,5-trimethoxyphenyl)ethanamine (also known as Mescaline-NBOMe or 3,4,5-trimethoxy-N-(2-methoxybenzyl)phenethylamine).~~

~~(r) 2-(4-chloro-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine (also known as 2C-C-NBOMe; 25C-NBOMe or 2,5-Dimethoxy-4-chloro-N-(2-methoxybenzyl)phenethylamine).~~

~~(s) 2-(7-Bromo-5-methoxy-2,3-dihydro-1-benzofuran-4-yl)ethanamine (also known as 2GB-5-hemiFLY).~~

~~(t) 2-(8-bromo-2,3,6,7-tetrahydrofuro[2,3-f][1]benzofuran-4-yl)ethanamine (also known as 2C-B-FLY).~~

~~(u) 2-(10-Bromo-2,3,4,7,8,9-hexahydropyrano[2,3-g]chromen-5-yl)ethanamine (also known as 2C-B-butterFLY).~~

~~(v) N-(2-Methoxybenzyl)-1-(8-bromo-2,3,6,7-tetrahydrobenzo[1,2-b:4,5-b']difuran-4-yl)-2-aminoethane (also known as 2C-B-FLY-NBOMe).~~

~~(w) 1-(4-Bromofuro[2,3-f][1]benzofuran-8-yl)propan-2-amine (also known as bromo-benzodifuranyl-isopropylamine or bromo-dragonFLY).~~

~~(x) N-(2-Hydroxybenzyl)-4-iodo-2,5-dimethoxyphenethylamine (also known as 2C-I-NBOH or 25I-NBOH).~~

~~(y) 5-(2-Aminopropyl)benzofuran (also known as 5-APB).~~

~~(z) 6-(2-Aminopropyl)benzofuran (also known as 6-APB).~~

~~(aa) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (also known as 5-APDB).~~

~~(bb) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (also known as 6-APDB).~~

~~(cc) 2,5-dimethoxyamphetamine (also known as 2,5-DMA).~~

~~(dd) 2,5-dimethoxy-4-ethylamphetamine (also known as DOET).~~

~~(ee) 2,5-dimethoxy-4-(n-propylthio)phenethylamine (also known as 2C-T-7).~~

~~(ff) 5-methoxy-3,4-methylenedioxy-amphetamine.~~

~~(gg) 4-methyl-2,5-dimethoxy-amphetamine (also known as 4-methyl-2,5-dimethoxy- $\alpha$ -methylphenethylamine; DOM and STP).~~

~~(hh) 3,4-methylenedioxy-amphetamine (also known as MDA).~~

~~(ii) 3,4-methylenedioxymethamphetamine (also known as MDMA).~~

~~(jj) 3,4-methylenedioxy-N-ethylamphetamine (also known as N-ethyl- $\alpha$ -methyl-3,4-(methylenedioxy)phenethylamine, MDE, MDEA).~~

~~(kk) 3,4,5-trimethoxy-amphetamine.~~

~~(ll) Mescaline (also known as 3,4,5-trimethoxyphenethylamine).~~

~~h. Substituted tryptamines. This includes any compound, unless specifically excepted, specifically named in this schedule, or listed under a different schedule, structurally derived from 2-(1H-indol-3-yl)ethanamine (i.e., tryptamine) by mono- or di-substitution of the amine nitrogen with alkyl or alkenyl groups or by inclusion of the amino nitrogen atom in a cyclic structure whether or not the compound is further substituted at the  $\alpha$ -position with an alkyl group or whether or not further substituted on the indole ring to any extent with any alkyl, alkoxy, halo, hydroxyl, or acetoxy groups. Examples include:~~

~~(1) 5-methoxy-N,N-diallyltryptamine (also known as 5-MeO-DALT).~~

~~(2) 4-acetoxy-N,N-dimethyltryptamine (also known as 4-AcO-DMT or O-Acetylpsilocin).~~

~~(3) 4-hydroxy-N-methyl-N-ethyltryptamine (also known as 4-HO-MET).~~

~~(4) 4-hydroxy-N,N-diisopropyltryptamine (also known as 4-HO-DIPT).~~

~~(5) 5-methoxy-N-methyl-isopropyltryptamine (also known as 5-MeO-MiPT).~~

~~(6) 5-Methoxy-N,N-Dimethyltryptamine (also known as 5-MeO-DMT).~~

~~(7) Bufotenine (also known as 3-(Beta-Dimethyl-aminoethyl)-5-hydroxyindole; 3-(2-dimethylaminoethyl)-5-indolol; N,N-dimethylserotonin; 5-hydroxy-N,N-dimethyltryptamine; mappine).~~

~~(8) 5-methoxy-N,N-diisopropyltryptamine (also known as 5-MeO-DiPT).~~

~~(9) Diethyltryptamine (also known as N,N-Diethyltryptamine; DET).~~

~~(10) Dimethyltryptamine (also known as DMT).~~

~~(11) Psilocyn.~~

~~i. 1-[3-(trifluoromethylphenyl)]piperazine (also known as TFMPP).~~

~~j. 1-[4-(trifluoromethylphenyl)]piperazine.~~

~~k. 6,7-dihydro-5H-indeno-(5,6-d)-1,3-dioxol-6-amine (also known as 5,6-Methylenedioxy-2-aminoindane or MDAI).~~

~~l. 2-(Ethylamino)-2-(3-methoxyphenyl)cyclohexanone (also known as Methoxetamine or MXE).~~

~~2. The following substances are hereby placed in schedule I of the Controlled Substances Act, North Dakota Century Code section 19-03.1-05, schedule I, subsection 7, stimulant substances:~~

~~a. Mephedrone (2-methylamino-1-p-tolylpropan-1-one) also known as 4-methylmethcathinone (4-MMC); 4-methylephedrone.~~

~~b. 3,4-Methylenedioxypropylone (MDPV).~~

~~c. Substituted cathinones. Any compound, material, mixture, preparation, or other product, unless listed in another schedule or an approved FDA drug (e.g., bupropion, pyrovalerone), structurally derived from 2-aminopropan-1-one by substitution at the 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the compound is further modified in any of the following ways:~~

~~(1) By substitution in the ring system to any extent with alkyl, alkylendioxy, alkoxy, haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring system by one or more other univalent substituents;~~

~~(2) By substitution at the 3-position with an acyclic alkyl substituent;~~

~~(3) By substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or methoxybenzyl groups; or~~

~~(4) By inclusion of the 2-amino nitrogen atom in a cyclic structure. Some trade or other names:-~~

~~(a) 3,4-Methylenedioxy-alpha-pyrrolidinopropiophenone (also known as MDPPP).~~

~~(b) 3,4-Methylenedioxy-N-ethylcathinone (also known as Ethylone, MDEC, or bk-MDEA).~~

~~(c) 3,4-Methylenedioxy-N-methylcathinone (also known as Methylone or bk-MDMA).~~

~~(d) 3,4-Methylenedioxypropylone (also known as MDPV).~~

~~(e) 3,4-Dimethylmethcathinone (also known as 3,4-DMMC).~~

~~(f) 2-(methylamino)-1-phenylpentan-1-one (also known as Pentedrone).~~

~~(g) 2-Fluoromethcathinone.~~

~~(h) 3-Fluoromethcathinone.~~

~~(i) 4-Methylethcathinone (also known as 4-MEC).~~

~~(j) 4-Fluoromethcathinone (also known as Flephedrone).~~

~~(k) 4-Methoxy-alpha-pyrrolidinopropiophenone (also known as MOPPP).~~

~~(l) 4-Methoxymethcathinone (also known as Methedrone; bk-PMMA).~~

~~(m) 4'-Methyl-alpha-pyrrolidinobutiophenone (also known as MPBP).~~

~~(n) Alpha-methylamino-butyrophenone (also known as Buphedrone or MABP).~~

~~(o) Alpha-pyrrolidinobutiophenone (also known as alpha-PBP).~~

~~(p) Alpha-pyrrolidinopropiophenone (also known as alpha-PPP).~~

~~(q) Alpha-pyrrolidinopentiophenone (also known as Alpha-pyrrolidinovalerophenone or alpha-PVP).~~

~~(r) Beta-keto-N-methylbenzodioxolylbutanamine (also known as Butylone or bk-MBDB).~~

~~(s) Ethcathinone (also known as N-Ethylcathinone).~~

~~(t) 4-Methylmethcathinone (also known as Mephedrone or 4-MMG).~~

~~(u) Methcathinone.~~

~~(v) N,N-dimethylcathinone (also known as metamfepramone).~~

~~(w) Naphthylpyrovalerone (also known as naphyrone).~~

~~d. Fluoroamphetamine.~~

~~e. Fluoromethamphetamine.~~

Substances on the drug enforcement administration's published exempt prescription product list are not considered controlled substances. Substances may be added to this section upon a rule change process in accordance with North Dakota Century Code section 19-03.1-02.

**History:** Effective February 26, 2010; amended effective December 3, 2012; October 1, 2019.

**General Authority:** NDCC 19-03.1-02, 19-03.1-05

**Law Implemented:** NDCC 19-03.1-02

**TITLE 75**  
**DEPARTMENT OF HUMAN SERVICES**



OCTOBER 2019

ARTICLE 75-03  
COMMUNITY SERVICES

Chapter	
75-03-01	Supplemental Parental Child Care and Family Day Care [Superseded]
75-03-01.1	Supplemental Parental Care and Family Day Care [Superseded]
75-03-02	Day Care Centers [Superseded]
75-03-02.1	Day Care Centers [Superseded]
75-03-03	Foster Care Group Homes [Superseded]
75-03-04	Residential Child Care Facilities [Superseded]
75-03-05	Family Boarding Homes for Students With Disabilities [Repealed]
75-03-06	Family Subsidy Program [Redesignated]
75-03-07	In-Home Child Care Early Childhood Services
75-03-07.1	Self-Declaration Providers Early Childhood Services
75-03-08	Family Child Care Homes Early Childhood Services
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75-03-12	Foster Parent Grievance Procedure
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75-03-15	Ratesetting for Providers of Services to Foster Children - <del>Group Homes and</del> <u>Qualified Residential <del>Child Care Facilities</del> Treatment Programs</u>
75-03-16	Licensing of Group Homes and Residential Child Care Facilities <u>[Repealed]</u>
75-03-17	Psychiatric Residential Treatment Facilities for Children
75-03-17.1	Authorized Agent in Providing Child Welfare Services
75-03-18	Procedures for Appeal of Child Abuse and Neglect Assessments
75-03-18.1	Child Abuse and Neglect Assessment Grievance Procedure for Conduct of the Assessment
75-03-19	Assessment of Child Abuse and Neglect Reports
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75-03-20	Ratesetting for Residential Treatment Centers for Children
75-03-21	Licensing of Foster Homes for Adults
75-03-22	Transitional Living [Repealed]
75-03-23	Provision of Home and Community-Based Services Under the Service Payments for Elderly and Disabled Program and the Medicaid Waiver for the Aged and Disabled Program
75-03-24	Expanded Service Payments For Elderly and Disabled
75-03-25	Ombudsman Program

75-03-26	Aging Services Community Programs Under the Older Americans Act [Repealed]
75-03-27	[Reserved]
75-03-28	[Reserved]
75-03-29	[Reserved]
75-03-30	[Reserved]
75-03-31	[Reserved]
75-03-32	Mill Levy [Repealed]
75-03-33	Intergovernmental Transfer Program
75-03-34	Licensing of Assisted Living Facilities
75-03-35	Provision of Medical Food and Low-Protein Modified Food Products to Individuals With Phenylketonuria and Maple Syrup Urine Disease
75-03-36	Licensing of Child-Placing Agencies
75-03-37	Transition-Aged Youth at Risk
75-03-38	Autism Spectrum Disorder Voucher Program
75-03-39	Autism Services Waiver
<u>75-03-40</u>	<u>Licensing of Qualified Residential Treatment Program Providers</u>
<u>75-03-41</u>	<u>Supervised Independent Living</u>

## CHAPTER 75-03-14 FAMILY FOSTER HOME FOR CHILDREN

### Section

75-03-14-01	Definitions
75-03-14-02	License
75-03-14-03	Minimum Physical Standards for the Family Foster Home for Children
75-03-14-04	Qualifications of Persons Residing in the Family Foster Home for Children
75-03-14-04.1	Criminal Conviction - Effect on Licensure
75-03-14-05	Operation of the Family Foster Home for Children
75-03-14-06	<del>Permanency Planning</del> Child and Family Team <u>Meeting</u>
75-03-14-07	Background Checks Required
75-03-14-08	Fingerprints Excused
75-03-14-09	Relative Licensing Waiver

### **75-03-14-01. Definitions.**

Those definitions set forth in North Dakota Century Code section 50-11-00.1 are applicable to this chapter. Additionally, in this chapter, unless the context or subject matter requires otherwise:

1. ~~"Adult" means a person twenty-one years of age or older.~~

~~2.~~ "Background check" means a ~~child protection services~~ fingerprint-based criminal history record investigation inclusive of a child abuse and neglect index check in each state or tribal jurisdiction that the individual has resided in the previous five years ~~and a criminal history record investigation.~~

~~3.~~ 2. "Reasonable and prudent parent standard" means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child participating in extracurricular, enrichment, cultural, and social activities.

~~4.~~ 3. "Regional center" means the regional human service center.

~~5.~~ 4. "Supervising agency" means the agency or person having care, custody, and control of the foster child as ordered by a court of competent jurisdiction or the designee of that agency or person.



**History:** Effective December 1, 1984; amended effective January 1, 2014; April 1, 2016; October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-00.1, 50-11-06.8

### **75-03-14-02. License.**

1. Application for a family foster home for children license must be made as prescribed by the department.
2. The family foster home for children licensing process requires completion and documentation of the following items, which must be received by the department for the application to be considered complete:
  - a. Application form;
  - b. Compliance with fire and safety requirements;
  - c. Reference letters;
  - d. Medical history self-declaration;
  - e. Background check;
  - f. Home visits; and
  - g. Home study assessment, including interviews with each member of the household as determined age appropriate.
3. The license is issued to the applicant for a specific number of children, a specified age group of the children, and the sex of the child or children. The duration of the license is not to exceed one year.
4. The department may issue a license with stated limitations, restrictions, and conditions.
5. The license is not transferable and is valid only for the physical location of the family foster home for children at the time the license is issued, or at another location ~~for a period not to exceed sixty days~~ as approved by the department, provided that the authorized agent performs an onsite visit within seven days of the move, and thereafter approves the temporary location.
6. After reviewing an individual's application for licensure, the department may deny a license:
  - a. If the application contains fraudulent information, an untrue representation, or is incomplete;
  - b. If the family foster home for children is in an unsanitary condition;
  - c. If the family foster home for children is not properly equipped to provide for the health and safety of the children served; or
  - d. If the applicant is not in compliance with the regulations prescribed by the department for the operation of a family foster home for children.
7. If the ~~home of a Native American family~~ facility located on or near, as defined by the tribe. a recognized Indian reservation in this state is identified as a family foster home for children, and is not subject to the jurisdiction of the state of North Dakota for family foster home for children licensing purposes, the department shall accept an affidavit from an agent of the tribal child welfare agency or an appropriate tribal officer in lieu of completing the licensing

procedure. The department shall issue an approval of the foster home for children if the affidavit represents the following:

- a. ~~An investigation~~A home study of the family foster home for children was completed by the tribe's child welfare agency or tribal council; and
- b. The prospective family foster home for children is in compliance with the standards adopted by the tribe for family licensing; or
- c. The prospective family foster home for children is in compliance with the standards required by North Dakota Century Code section 50-11-02.

**History:** Effective December 1, 1984; amended effective April 1, 2004; January 1, 2014; October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-01, 50-11-02

### **75-03-14-03. Minimum physical standards for the family foster home for children.**

1. The family foster home for children must be a dwelling, mobile home, housing unit, or apartment occupied by an individual or a single family.
2. The family foster home for children must have an operational telecommunications device, and residents of the home must have available access to it ~~some means~~ to make immediate contact with authorities in emergencies.
3.
  - a. The family foster home for children must have adequate sleeping rooms ~~adequate for the foster care family and the foster children to accommodate the size of the household, including an individual bed and bedding for each foster child to sleep comfortably.~~
  - b. All sleeping rooms must ~~be outside rooms and~~ have ample an accessible window ~~space to exit and to allow~~ for proper light and ventilation and appropriate fire alarms or smoke detectors as recommended by the local fire department, state fire marshal, or local building codes.
  - c. Basement sleeping rooms must be equipped ~~with the appropriate fire alarms and smoke detectors as recommended by the local fire department or state fire marshal. A basement which will be used for the care of foster children must be equipped~~ with more than one exit. ~~One exit may be an accessible window. Children~~Foster children in basement sleeping rooms must be able to demonstrate their ability to depart from all exits.
  - d. Co-sleeping or bed sharing with a foster child is prohibited.
4. Exterior doors must be maintained to permit easy exit.
5. Interior doors must prevent children from being trapped.
- 5-6. Every closet door must be one that can be opened from the inside. Bathroom doors must be installed so the door, when locked, may be opened from the outside in an emergency.
- 6-7. The ~~house~~family foster home for children and premises must be clean, neat, and free from hazards that jeopardize health and safety. The family foster home for children shall engage in proper trash disposal and be free from rodent and insect infestation.
8. Firearms must be kept in locked storage or trigger locks must be used, and ammunition must be kept separate from firearms. A household member with a concealed weapons permit shall follow the regulations set forth in state law.

- ~~7.9.~~ The family foster home for children must be equipped with adequate light, heat, ventilation, and plumbing for safe and comfortable occupancy. The family foster home for children shall have a properly operating sink, refrigerator, stove, and oven in the kitchen and at least one sink, toilet, and bathtub or shower in the bathroom.
- ~~10.~~ The ~~house~~family foster home for children and grounds must be in compliance with any applicable state and local zoning requirements.
- ~~8.11.~~ ~~Any source other than~~The water supply must be from an approved municipal water supply ~~must be tested annually for compliance for approved drinking water standards. The sample must be sent to the North Dakota department of health or a United States~~system where available. Where a municipal system is not available, a water sample must pass the approved drinking water standard bacteriological water analysis testing. The family foster home for children shall obtain results from an environmental protection agency approved laboratory for testing ~~and approval. The results must be submitted to the department~~through licensing with the department of environmental quality. In addition, the family foster home for children shall ensure the water temperature is monitored for safety.
- ~~9.12.~~ The milk supply consumed in the family foster home for children must be obtained from a department-approved source.
- ~~10.13.~~ If required by the department, the family foster home for children must satisfactorily complete a fire inspection by the local fire inspector or, in the absence of a local fire inspector, the state fire marshal. The ~~adult in charge of the~~family foster home for children shall ensure all deficiencies noted during the inspection are remedied.
- ~~11.14.~~ The family foster home for children must be equipped with the approved Underwriters' Laboratories fire extinguishers, smoke detectors, and smoke alarms as recommended by the local fire inspector ~~or~~, state fire marshal, or building code. The fire extinguishers, smoke detectors, and smoke alarms must be in working condition at all times. In an apartment building, the fire extinguisher, smoke detectors, and smoke alarms must be inside the apartment unit.
- ~~15.~~ The family foster home for children shall have reliable, legal, and safe transportation available to transport children in placement.
- ~~16.~~ The family foster home for children shall be equipped with a carbon monoxide detector.
- ~~17.~~ The family foster home for children shall develop a written emergency preparedness plan, maintain and post a list of emergency contacts, including poison control, and have first aid supplies on hand while a foster child is in placement.
- ~~18.~~ The family foster home for children shall properly store medications, alcohol, poisonous materials, cleaning supplies, and other hazardous materials to prevent access to children, as appropriate for age and development of the children in placement.
- ~~19.~~ Pets belonging to the foster family must be properly vaccinated as per veterinary guidelines.
- ~~20.~~ Swimming pools in the ground or an aboveground pool with a depth of four feet or greater must have a barrier on all sides to minimize unsupervised access. The barrier must be equipped with a safety lock. If the pool cannot be drained, the swimming pool must have a working pump and filtering system. The pool area must have a life saving device available in the event of an emergency. This standard does not apply to a small wading pool.
- ~~21.~~ Hot tubs on the premises of a foster home for children must have safety code covers that are locked when not in use.

**History:** Effective December 1, 1984; amended effective July 1, 1993; April 1, 2004; January 1, 2014; April 1, 2016; October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

**75-03-14-04. Qualifications of persons residing in the family foster home for children.**

1. An applicant for licensure must:

(a) Be age twenty-one years or greater;

(b) Be financially stable with reasonable income or resources available to the home to properly care for children; and

(c) Have functional literacy, demonstrating their ability to read licensing policy, handbook, child care plans, and medication labels.

2. A person residing in the family foster home for children, except a foster child or ward of the court, may not ~~have a present condition~~ exhibit symptoms of substance abuse or emotional instability that inhibit their ability to care for children.

~~2.3.~~ No person may smoke or vape in the family foster home for children, in circumstances which present a hazard to the health of the foster child, or in an enclosed area when the foster child is present. All foster parents must be aware of the potential hazards of smoking in the presence of children, particularly infants and children with respiratory or allergic sensitivity.

~~3.4.~~ If ~~a condition~~ symptoms of substance abuse or emotional instability ~~occurs~~ that inhibit the ability to care for children occur in a family foster home for children at a time when a foster child is in placement, every effort should be made to keep the placement intact if the ~~resident of the family foster home for children who is suffering from substance abuse or emotional instability~~ household member is seeking treatment ~~for the condition.~~ The supervising agency may make no further placements in that family foster home for children until the ~~resident suffering from the condition~~ household member successfully completes treatment ~~for the condition.~~ A resident of a family foster home for children, who has a past condition of if a household member has symptoms of substance abuse or emotional instability, the household member may have had no incidents ~~of substance abuse or emotional instability~~ which inhibited their ability to care for children for a period of at least twelve months prior to an applicant obtaining licensure.

~~4.5.~~ A ~~resident of the family foster home for children~~ member of the household, except a foster child, may not have been the subject of a child abuse or neglect assessment where a services-required decision was made unless the ~~director or foster care supervisor of the regional center~~ department, after making appropriate consultation with persons qualified to evaluate the capabilities of the ~~resident~~ household member, documenting criteria used in making the decision, and imposing any restrictions deemed necessary, approves the issuance of a license; and

a. The ~~resident can demonstrate the successful completion of an appropriate therapy~~ household member has followed the recommendations of the child protection team; or

b. The ~~resident~~ household member can demonstrate the elimination of an underlying basis precipitating the neglect or abuse.

~~5.6.~~ Prior to the department approving a license, the applicant shall submit the results of a physical examination dated within twelve months of the date of application. All foster parents, ~~prior to licensing and~~ annually thereafter, shall submit a declaration of good health, including all

residents of the family foster home for children, except any foster child, in a manner and form required by the department. ~~The department may require a physical examination or psychological testing of any resident of the family foster home for children as the department determines necessary.~~ The cost of any physical examinations required pursuant to this subsection is the responsibility of the authorized agent. ~~The cost of any psychological testing required pursuant to this subsection is the responsibility of the department.~~

~~6-7.~~ The department may require proof of immunizations for all residents living in the family foster home for children, except any foster child. It is recommended all members of the household be up to date on immunizations as recommended by a health care professional, unless the immunization is contrary to the person's health as documented by a licensed health care professional or the person provides written documentation that immunizations are against the person's religious, philosophical, or moral beliefs.

8. The department may require foster parents specializing in the care of medically fragile infants and children to receive specific vaccines if the needs of the child require such precaution, such as influenza or pertussis.

9. The department may require psychological testing of any resident of the family foster home for children as determined necessary. The cost of any psychological testing required pursuant to this subsection is the responsibility of the department.

10. Physical disabilities or age of foster parents do not affect licensing of the family foster home for children provided that the applicant can show that these factors do not significantly inhibit the ability of the foster parents to efficiently carry on the duties required of them.

~~7-11.~~ All foster parents or potential parents must demonstrate a working knowledge and comply with the department's approved family foster home for children preservice training competencies.

~~8-12.~~ All foster parents or potential parents must demonstrate a working knowledge of the reasonable and prudent parent standard by allowing foster children the opportunity to participate in developmentally and age appropriate activities. All foster parents must engage in the reasonable and prudent parent standard.

~~9-13.~~ ~~Initial and annual fire safety training hours will not be counted toward the minimum number of training hours required for initial or annual licensing~~ Fire safety training is required annually.

**History:** Effective December 1, 1984; amended effective April 1, 2004; July 1, 2006; January 1, 2014; April 1, 2016; October 1, 2019.

**General Authority:** NDCC 50-11-03, 50-11-03.4

**Law Implemented:** NDCC 50-11-02

#### **75-03-14-04.1. Criminal conviction - Effect on licensure.**

1. A family foster home for children applicant, family foster home for children provider, or adult members of residing in the family foster home for children must not be known to have been found guilty of, pled guilty to, or pled no contest to:
  - a. An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-17, assaults - threats - coercion - harassment; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or ~~12.1-40, human trafficking~~ 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-12.3, sexual extortion; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-22-01, robbery; or 12.1-22-02, burglary, if a class B felony under



subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; or 12.1-31-05, child procurement; ~~or 12.1-31-07, endangering an eligible adult - penalty; 12.1-31-07.1, exploitation of an eligible adult - penalty;~~ 14-09-22, abuse ~~or neglect of a child;~~ or 14-09-22.1, neglect of child;

- b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or
  - c. An offense, other than an offense identified in subdivision a or b, if the department determines that the individual has not been sufficiently rehabilitated.
    - (1) The department will not consider a claim that the individual has been sufficiently rehabilitated until any term of probation, parole, or other form of community corrections or imprisonment, without a subsequent charge or conviction, has elapsed.
    - (2) An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, is prima facie evidence of sufficient rehabilitation.
2. The department has determined that the offenses enumerated in subdivisions a and b of subsection 1 have a direct bearing on an individual's ability to provide foster care for children.
  3. If the offense is a misdemeanor simple assault described in North Dakota Century Code section 12.1-17-01, or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that an individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction. The department may not be compelled to make such determination.
  4. The department may discontinue processing a request for a criminal background check for any individual who provides false or misleading information about the individual's criminal history.
  5. An individual is known to have been found guilty of, pled guilty to, or pled no contest to an offense when it is:
    - a. Common knowledge in the community;
    - b. Acknowledged by the individual; or
    - c. Discovered by the authorized agent or department as a result of a background check.

**History:** Effective April 1, 2004; amended effective January 1, 2014; April 1, 2016; October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-14-05. Operation of the family foster home for children.**

1. The foster parents shall ~~admit~~ allow public officials to enter the family foster home for children; ~~public officials, such as fire and building inspectors, for the purpose of determining fire and building as determined necessary by the public official to ensure safety.~~

2. The foster parents shall ~~admit~~allow entry to the family foster home for children, at any reasonable time, personnel of the supervising agency. For the purposes of this subsection, "any reasonable time" means a time mutually convenient to the foster parents and the supervising agency's personnel or any time the supervising agency determines that a foster child's health, safety, or welfare require the admittance.
3. The foster parents shall cooperate with the supervising agency in that agency's efforts to develop plans for the child, implement those plans, and meet the needs of the child and the child's family. The foster parents shall cooperate with the supervising agency in developing plans for the child to visit with the child's parents or guardian. If the foster parents agree, and it is appropriate, these visits may take place in the family foster home for children. Visits between the foster child and the child's parents or guardian must be arranged within a plan approved by the agency, foster child where appropriate, foster parents, and the foster child's parents or guardian. The foster parents ~~need not admit~~do not have to allow entry to any individual who has been using alcohol, drugs, or any other intoxicating substance, or who attempts a visit in a manner that is not in accordance with the approved visitation plan.
4. The foster parents may not accept other foster children or special education boarding care children, foreign exchange students, or ~~accept~~ children for supplemental parental care into their family foster home for children without the prior approval of the authorized ~~agency~~agent. All changes in the number of persons living in the foster home must be immediately reported to the authorized ~~agency~~agent.
5. When a foster child is placed in substitute care during the absence of the foster parents, prior approval of the substitute care must be given by the supervising agency. Prior approval is not required for short periods of substitute care such as a portion of one day. A foster child may not be removed from this state without the prior approval of the supervising agency.
6. The foster parents must make opportunities available for a foster child to attend religious ceremonies chosen by the foster child, or that child's parents, within the community in which the foster family resides. The foster parents must respect and not interfere with the religious belief of the foster child and the foster child's family.
7. Discipline must be constructive or educational in nature and may include diversion, separation from problem situation, talk with the foster child about the situation, praise for appropriate behavior, and gentle physical restraint such as holding.
  - a. No foster child may be kicked, bitten, punched, spanked, shaken, pinched, roughly handled, or struck with an inanimate object by foster parents or any other ~~adult~~resident living in the family foster home for children.
  - b. Cruel and unusual punishments are prohibited.
  - c. Authority to discipline may not be delegated to or be accomplished by children.
  - d. Separation, when used as discipline, must be brief and appropriate to the foster child's age and circumstances, and when used to discipline a foster child, must be within hearing of an adult in a safe, lighted, well-ventilated room. A foster child may not be isolated in a locked room or closet.
  - e. A foster child may not be physically disciplined for lapses in toilet training.
  - f. Verbal abuse or derogatory remarks about a foster child, the foster child's family, race, religion, sexual orientation, gender identity, or cultural background may not be used and are not permitted.

- g. A foster child may not be force fed unless medically prescribed and administered under a physician's care.
  - h. Deprivation of means, including food, clothing, shelter, hygiene, and medical care, may not be used as a form of discipline.
8. All information given to the foster parents by the supervising agency or the foster child's family concerning the foster child must remain confidential and may not be disclosed to any person without prior approval of the supervising agency.
  9. All family foster care for children maintenance payments must be used to meet the needs of the foster child.

**History:** Effective December 1, 1984; amended effective April 1, 2004; January 1, 2014; October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

**75-03-14-06. ~~Permanency planning child~~ Child and family team meeting.**

1. Every ~~county social service board~~ foster child shall have a ~~county~~ permanency ~~planning plan reviewed by a~~ child and family team that meets not less than once each quarter in which the county social service board, human service zone, division of juvenile services, or tribe acts as a supervising agency to ~~any~~ the foster child. ~~If the county social service board acts as supervising agency for five or more children in foster care, the county permanency planning child and family team must meet at least once each month.~~ The ~~permanency planning~~ child and family team will be cochaired by the ~~regional supervisor~~ department and the ~~county~~ supervising agency director or ~~their~~ designee.
2. The supervising agency shall invite the foster child's parents, the foster parents, and the guardian ad litem to participate in the ~~permanency planning~~ child and family team for the foster child unless good cause exists to exclude any person from the planning meeting. The supervising agency shall determine the good cause basis and shall document the basis in the foster child's file.
3. The foster parents shall participate in the ~~permanency planning~~ child and family team meetings for the foster child. The foster parents shall cooperate in carrying out the objectives and goals of the plan for the foster child in their care. Foster parents may be considered, but are not guaranteed, to be a permanency option for the child. Foster parents shall sign an acknowledgment that federal law establishes a permanency preference for a relative of the foster child.
4. The foster parents, when requested by the supervising agency or the juvenile court, shall provide ~~requested~~ information concerning the foster child and the child's family.
5. The foster parents and the supervising agency, working in cooperation, must attempt to maintain and improve the relationships between the foster child and the child's family whenever appropriate and possible. The foster parents may not attempt to diminish the relationship between the foster child and the child's parents or between the supervising agency ~~staff~~ and the foster child.

**History:** Effective December 1, 1984; amended effective April 1, 2004; July 1, 2006; January 1, 2014; October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02



#### **75-03-14-07. Background checks required.**

Background checks are required for all adults ~~living~~residing in the family foster home for children:

1. Prior to initial licensure or approval to provide a family foster home for children ~~licensure or approval~~;
2. If there is a lapse of license or approved status of the family foster home for children; or
3. In the case of a foster parent grandfathered in as of August 1, 1999, or after the initial background check was completed, whenever a licensed or approved foster care parent or other adult living in the family foster home for children is known to have been involved in, charged with, or convicted of an offense.
4. Annually, a child abuse and neglect index check must be completed as part of the licensing renewal process.

**History:** Effective April 1, 2004; amended effective January 1, 2014; October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02, 50-11-06.8

**CHAPTER 75-03-15**  
**RATESETTING FOR PROVIDERS OF SERVICES TO FOSTER CHILDREN - ~~GROUP~~**  
**~~HOMES AND~~QUALIFIED RESIDENTIAL ~~CHILD CARE FACILITIES~~TREATMENT**  
**PROGRAMS**

Section	
75-03-15-01	Definitions
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75-03-15-03	Child Census
75-03-15-04	Ratesetting
75-03-15-05	Cost Allocation
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75-03-15-11	Related Organization
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75-03-15-14	Cost Allowability and Limitations
75-03-15-15	Variance
75-03-15-16	Reconsiderations and Appeals

**75-03-15-01. Definitions.**

1. "Accrual basis" means the recording of revenue in the period revenue is earned, regardless of when revenue is collected, and the recording of expenses in the period expenses are incurred regardless of when expenses are paid.
2. "Administration" means the cost of activities performed by the facility employees in which the direct recipient of the activity is the organization itself. These include fiscal activities, statistical reporting, recruiting, and general office management which are indirectly related to services for which a rate is set.
3. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by this chapter.
4. "Chain organization" means a group of two or more program entities which are owned, leased, or, through any other device, controlled by one business entity.
5. "Department" means the North Dakota department of human services.
6. "Facility" means a qualified residential ~~child care facility or group home~~treatment program.
7. "Historical cost" means those costs reported on the cost statement which were incurred and recorded in the facility's accounting records.
8. "Home office" means the single business entity that controls a group of two or more facilities owned, leased, or through any other device, including proprietary chains and chains operated by various religious or other charitable organizations. A chain organization may also include business organizations engaged in activities not directly related to child residential care.
9. "Interest" means the cost incurred with the use of borrowed funds.

10. "Professional social services" means case management and therapeutic services offered by an employee directly to the children in placement in the facility.

11. "Qualified residential treatment program" means a licensed or approved residence providing an out-of-home treatment placement for children.

12. "Rate year" means the twelve-month period beginning the seventh month after the end of a facility's fiscal year.

~~12.~~13. "Reasonable cost" means the cost of providing food, clothing, shelter, daily supervision, school supplies, and personal incidentals for children in placement, employee liability insurance with respect to children in placement, travel of a child in placement to the child's home for visitation, and operation of the facility which must be incurred by an efficient and economically operated facility to provide services in conformity with applicable federal and state laws, regulations, rules, and quality and safety standards. Reasonable cost takes into account that the facility seeks to minimize costs and that actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service.

~~13.~~14. "Related organization" means an organization which a facility is, to a significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the facility. Control exists if an individual or organization has the power, directly or indirectly, to significantly influence or direct the policies of an organization or facility.

~~14.~~15. "Report year" means the facility's fiscal year.

~~15.~~16. "Usable square footage" means the allocation of the facility's total square footage, excluding common areas, identified first to a cost category and then allocated based on the allocation method described for that cost category.

**History:** Effective November 1, 1985; amended effective March 1, 1999; June 1, 2004; July 1, 2014; October 1, 2019.

**General Authority:** NDCC 50-06-16, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03.2

### **75-03-15-03. Child census.**

1. A facility shall maintain a daily child census record. The facility shall count any day for which services are provided or payment is ordinarily sought for an available bed, including the day of discharge, as a one day for the child census. The day of admission or death must be counted.
2. A facility shall prepare and maintain child census records on a daily basis to allow for proper audit of the child census data. The daily child census records must include:
  - a. Identification of the child in placement;
  - b. Entries for all days a child is in placement;
  - c. Identification of type of day: general facility programming, shelter care, or ~~out-based program~~respite care; and
  - d. Monthly totals by child in placement and by type of day.

**History:** Effective November 1, 1985; amended effective March 1, 1999; July 1, 2014; October 1, 2019.

**General Authority:** NDCC 50-06-16, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03.2

#### **75-03-15-04. Ratesetting.**

1. The department shall base the established rate on prospective ratesetting procedures. The establishment of a rate begins with historical costs. Adjustments are then made for claimed costs which are not includable in allowable costs. Adjustment factors are then applied to allowable costs. The department may not make retroactive settlements for actual costs incurred during the rate year which exceed the final rate unless specifically authorized in this chapter.
2. Desk audit rate.
  - a. The department shall establish desk audit rates for maintenance, based on the cost report, which will be effective the first day of the seventh month following the facility's fiscal yearend.
  - b. The desk rates will continue in effect until final rates are established.
  - c. The department shall review the cost report taking into consideration the prior year's adjustments. The department shall notify a facility by telephone, electronic mail, or mail of any desk adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why a desk adjustment should not be made. The department will review the submitted information, make appropriate adjustments, including adjustment factors, and issue the desk rates.
  - d. The department may not reconsider the desk rates unless the facility has been notified that the desk rates are the final rates.
3. Final rate.
  - a. The department may perform a field audit of the cost report to establish final rates. If no field audit is performed, the desk rates will become the final rates upon notification to the facility from the department.
  - b. The final rate for maintenance will be effective beginning the first day of the month in which notification of the rate is given to the facility.
  - c. The final rate will include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk rate of at least five cents per day.
  - d. Adjustments, errors, or omissions which are found after a final rate has been established will be included as an adjustment in the report year that the adjustments, errors, or omissions are found.
4. Special rates.
  - a. Facilities providing services for the first time.
    - (1) The department shall establish rates for a facility which is providing services which are purchased by the department using the following methodology for the first two fiscal years of the facility if such period is less than twenty-four months.
      - (a) The facility shall submit a budget for the first twelve months of operation. The department shall establish a final rate for a rate period which begins on the first of the month in which the facility begins operation. This rate will remain in effect for eighteen months. No adjustment factors will be included in the first-year final rate.

- (b) Upon completion of the first twelve months of operation, the facility shall submit a cost report for the twelve-month period regardless of the fiscal yearend of the facility.
  - [1] The twelve-month cost report is due on or before the last day of the third month following the end of the twelve-month period.
  - [2] The department shall use a twelve-month cost report to establish a rate for the remainder of the second rate year. The department shall use appropriate adjustment factors to establish the rate.
- (2) The facility shall submit a cost report that the department will use to establish rates in accordance with subsections 2 and 3 after the facility has been in operation for the entire twelve months of the facility's fiscal year.
- b. Facilities changing ownership.
  - (1) For facilities changing ownership, the rate established for the previous owner will be retained until the end of the rate year in which the change occurred.
  - (2) The department shall establish the rate for the second rate year after a change in ownership occurs as follows:
    - (a) For a facility with four or more months of operation under the new ownership during the report year, the department shall use a cost report for the period since the ownership change occurred to establish the rate for the next rate year.
    - (b) For a facility with less than four months of operation under the new ownership in the reporting year, the department shall index forward the prior report year's costs as adjusted for the previous owner using appropriate adjustments.
- c. Facilities having a capacity increase or major renovation or construction.
  - (1) For facilities which increase licensed capacity by twenty percent or more or have renovation or construction projects in excess of fifty thousand dollars, the department may adjust the rate established for the rate year in which the licensed increase occurs or the construction or renovation is complete to include projected property costs. The department shall calculate the adjusted rate based on a rate for historical costs, exclusive of property costs, as adjusted, divided by historical child census, plus a rate for property costs based on projected property costs divided by projected child census. The established rate for maintenance, including projected property costs, will be effective on the first day of the month in which notification of the rate is given to the facility after the renovation or construction is complete or the licensed capacity increased.
  - (2) For the rate year immediately following the rate year in which the capacity increase occurred or construction and renovation was completed, the department shall establish a rate based on historical costs, exclusive of property costs, as adjusted for the report year, divided by reported child census, plus a rate for property costs, based on projected property costs, divided by projected child census.
- d. Facilities that have changes in services or employees.
  - (1) The department may provide for an increase in the established rate for additional costs that are necessary to add services or employees to the existing program.

- (2) The facility shall submit information to the department supporting the request for the increase in the rate. Information must include a detailed listing of new or additional employees or costs associated with the increase in services.
  - (3) The department will review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the department shall adjust the established rate. The effective date of the rate increase will be on the first of the month following approval by the department. The adjustment will not be retroactive to the beginning of the rate year.
  - (4) For the rate year immediately following a rate year in which a rate was adjusted under paragraph 3, the facility may request that consideration be given to additional costs. The facility must demonstrate to the department's satisfaction that historical costs do not reflect twelve months of actual costs of the additional employees or added services in order to adjust the rate for the second rate year. The additional costs would be based on a projection of costs for the remainder of a twelve-month period.
5. The final rate must be considered as payment for all accommodations which include items identified in section 75-03-15-07. For any child in placement whose rate is paid in whole or in part by the department, the facility may not solicit or receive payment from the child in placement or any other person to supplement the rate as established.
6. For a facility terminating its participation in the program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until all children in placement can be relocated.
7. The historical costs combined with the adjustments take into consideration the economic conditions and trends during the period to be covered by the rate. A facility may request any adjustments to provide appropriate compensation if major unforeseeable expenses are incurred. A facility shall make any request for rate adjustment to the department, which shall determine if the expense is child-related.
8. Limitations.
  - a. The department may accumulate and analyze statistics on costs incurred by the facilities. The department may use these statistics to establish cost ceilings and incentives for efficiency and economy, based on a reasonable determination of the standards of operations necessary for efficient delivery of needed services. The department may establish these limitations and incentives on the basis of the cost of comparable facilities and services and the department may apply these limitations and incentives as ceilings on the overall costs of providing services or on specific areas of operations.
  - b. When federal regulations establish a ceiling on foster care rates for these facilities, that ceiling must also be considered the maximum payment under title IV-E of the Social Security Act, [42 U.S.C. 670 et seq.].
  - c. A facility shall maintain an average annual occupancy rate of seventy-five percent. Shelter and respite care beds designated by the facility and approved by the department are exempt from the occupancy rate percentage requirement. The computed child census days apply only to the following areas:
    - (1) Administrative costs;
    - (2) Plant operation costs; and
    - (3) Property costs.

~~A reserved paid bed is counted as an occupied bed.~~ The department may waive the minimum bed occupancy allowance for a facility. A facility requesting a waiver shall include an adequate explanation as to why the referenced allocation method cannot be used by the facility. The facility also shall provide a rationale for the proposed allocation method. Based on the information provided, the department shall determine the allocation method used to report costs.

d. Administrative costs must be limited to the percent of total allowable costs exclusive of administrative costs, authorized by the department.

9. Rate adjustments.

a. The department may apply adjustment factors to adjust historical costs. The department shall annually determine an appropriate adjustment factor to be applied to allowable costs exclusive of property costs.

b. The department may make rate adjustments to correct departmental errors subsequently identified.

c. The department shall make an adjustment for those facilities which have terminated participation in the program, disposed of depreciable assets, or changed ownership.

10. The department shall continue to pay the established rate of a facility previously licensed as a residential child care facility prior to October 1, 2019, upon the facility's licensure as a qualified residential treatment program. The department may adjust the rate in accordance with this section.

**History:** Effective November 1, 1985; amended effective July 1, 1993; March 1, 1999; August 1, 2002; June 1, 2004; July 1, 2014; October 1, 2019.

**General Authority:** NDCC 50-06-16, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03.2

**75-03-15-07. Allowable costs for maintenance and administration.**

1. **Maintenance rate.** Costs includable in the rate for room and board include those described in this subsection, unless limited by section 75-03-15-09.

a. Salary and fringe benefits for direct care employees, which must be limited to:

(1) The childdirect care workers' supervisor;

(2) ChildDirect care workers;

(3) Relief childdirect care workers;

(4) Cooks;

(5) Janitors and housekeepers;

(6) Laundry; and

(7) Nurses when performing daily supervision, children in placement physical examinations, and medical care treatment. If the nurse is providing daily supervision, children in placement physical examinations, medical care treatment and other services, a time study will need to be completed. The portion that is daily supervision, children in placement physical examinations, and medical care treatment may be included in the calculation of the daily rate for maintenance.

- b. Food. Actual food costs. The value of donated food may not be included in food costs.
- c. Operating supplies. The cost of supplies necessary to maintain the household for the children in placement. Costs include cleaning supplies, paper products, and hardware supplies.
- d. Personal supplies and allowances. The cost of supplies used by an individual child in placement, including medicine chest supplies, personal hygiene items, sanitary needs, and moneys given periodically to children in placement for personal use. Personal supplies and allowances do not include payment, whether in cash or in kind, for work performed by the children in placement or for bonuses or rewards paid based on behavior.
- e. School supplies. The cost of school supplies, books, activity fees, class dues, and transportation to school.
- f. Clothing. The cost of clothing to maintain a wardrobe for any child in placement.
- g. Recreation. Costs incurred for providing recreation to children in placement, including magazine and newspaper subscriptions, sports equipment, games, dues for clubs, and admission fees to sporting, recreation, and social events.
- h. Utilities. The cost of heat, lights, water, sewage, garbage, and common area cable or satellite TV.
- i. Telephone. The cost of local service to the living quarters. Long distance calls are allowable only if specifically identified as being related to maintenance and are not service or administrative in nature. Cellular telephones or electronic communication systems, including associated monthly service fees which are less than the capitalization threshold, and are purchased by the facility for use by direct care employees to communicate for the purpose of child safety, programming, transportation, and supervision while on shift are allowable telephone costs.
- j. Repairs. The cost of routine repairs and upkeep of property and equipment used for the children in placement. The facility shall capitalize and depreciate repair or maintenance costs in excess of five thousand dollars per project on equipment or over the remaining useful life of the equipment or building or over one-half of the original estimated useful life, whichever is greater.
- k. Travel. All costs related to transporting children in placement, exclusive of transportation for evaluations and social service activities. Transportation costs may include actual vehicle expenses or actual costs not to exceed the amount established by the internal revenue service.
- l. Leases and rentals. The cost of leasing assets from a nonrelated organization. If the lease cost cannot be directly associated with a function, the department shall allocate the cost in accordance with section 75-03-15-05.
- m. Depreciation expense. Depreciation expense on all capitalized equipment and property which was not purchased with funds made available through other government programs or grants is allowable.
- n. Insurance. The cost of insuring property and equipment used in the maintenance of children in placement and liability insurance for direct care employees.
- o. Medical. Costs for necessary medical-related items for children in placement which are not covered by insurance or governmental medical care programs, provided that facility



records demonstrate that the facility has made reasonable attempts to secure insurance or program benefits. Costs may include physical examinations, drugs, dental work, corrective appliances, and required medical care and treatment for children in placement.

- p. Administration. Costs of administration which do not exceed limitations, provided that the department, in its discretion, may exclude costs of administration based upon a lack of appropriated funds.

2. **Administration costs.** Unless limited by section 75-03-15-09, administration costs are allocated in accordance with section 75-03-15-04, subsection 4 of section 75-03-15-05, and this subsection. Costs for administration include only those allowable costs for administering the overall activities of the facility identified as follows:

- a. Compensation for employees, such as administrators, accounting employees, clerical employees, secretaries, receptionists, data processing employees, purchasing employees, and security employees;
- b. Office supplies and forms;
- c. Insurance, except property insurance directly identified to other cost categories, and insurance included as a fringe benefit;
- d. The cost of telephone service not specifically included in other cost categories;
- e. Postage and freight;
- f. Professional fees for legal, accounting, and data processing;
- g. Computer software costs, except costs that must be capitalized, and computer maintenance contracts;
- h. Central or home office costs;
- i. Employee recruitment costs;
- j. Management consultants and fees;
- k. Dues, license fees, and subscriptions;
- l. Travel and training not specifically included in other costs categories;
- m. The cost of heating and cooling, electricity, and water, sewer, and garbage for space used to provide administration;
- n. The cost of routine repairs and maintenance of property and equipment used to provide administration;
- o. The cost of plant operation and housekeeping salaries and fringe benefits associated with the space used to provide administration;
- p. Property costs. Depreciation, interest, taxes, and lease costs on equipment and buildings for space used to provide administration;
- q. Startup costs; or
- r. Any costs that cannot be specifically classified or assigned as a direct cost to other cost categories.

**History:** Effective November 1, 1985; amended effective March 1, 1999; June 1, 2004; July 1, 2014; [October 1, 2019](#).

**General Authority:** NDCC 50-06-16, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03.2

#### **75-03-15-12.1. Startup costs.**

In the first stages of operation, a new facility incurs certain costs in developing the ability to care for children prior to admission. Employees are obtained and organized, and other operating costs are incurred during this time of preparation which cannot be allocated to facility direct care during that period because there are no children in placement receiving services. These costs are commonly referred to as startup costs. The startup costs are to be capitalized and must be recognized as allowable administration costs amortized over sixty consecutive months starting with the month in which the first child is admitted. [This section does not apply to a facility transitioning from a residential child care facility on October 1, 2019, to a qualified residential treatment program.](#)

**History:** Effective March 1, 1999; amended effective July 1, 2014; [October 1, 2019](#).

**General Authority:** NDCC 50-06-16, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03.2

**CHAPTER 75-03-16**  
**LICENSING OF GROUP HOMES AND RESIDENTIAL CHILD CARE FACILITIES**

[Repealed effective October 1, 2019]

Section

- ~~75-03-16-01 — Definitions~~
- ~~75-03-16-02 — Effect of License~~
- ~~75-03-16-02.1 — Application for License~~
- ~~75-03-16-02.2 — Provisional License~~
- ~~75-03-16-02.3 — Correction Orders~~
- ~~75-03-16-02.4 — Fiscal Sanctions~~
- ~~75-03-16-02.5 — Denial or Revocation of License or Endorsement~~
- ~~75-03-16-02.6 — Residential Bed Conversion~~
- ~~75-03-16-03 — Organization and Administration~~
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- ~~75-03-16-05 — Employee and Nonemployee Files~~
- ~~75-03-16-06 — Facility Administrator~~
- ~~75-03-16-07 — Program Director~~
- ~~75-03-16-08 — Social Service Employees~~
- ~~75-03-16-09 — Social Service Employee Supervision~~
- ~~75-03-16-10 — Direct Care Employees~~
- ~~75-03-16-10.1 — Nursing Services~~
- ~~75-03-16-11 — Nonemployees~~
- ~~75-03-16-12 — Employment Policies~~
- ~~75-03-16-12.1 — Criminal Conviction — Effect on Operation of Facility or Employment by Facility~~
- ~~75-03-16-12.2 — Employee and Nonemployee Background Checks~~
- ~~75-03-16-12.3 — Employee and Nonemployee Health Requirements~~
- ~~75-03-16-13 — Minimum Employee Requirements~~
- ~~75-03-16-14 — Employee Professional Development~~
- ~~75-03-16-15 — Child Abuse and Neglect~~
- ~~75-03-16-16 — Preadmission, Admission, and Discharge~~
- ~~75-03-16-17 — Case Plan~~
- ~~75-03-16-18 — Interstate Compact on the Placement of Children~~
- ~~75-03-16-19 — Law Enforcement Notification~~
- ~~75-03-16-19.1 — Sentinel Event Reporting~~
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- ~~75-03-16-20 — Programs and Services~~
- ~~75-03-16-21 — Case File~~
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- ~~75-03-16-26 — Discipline~~
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- ~~75-03-16-28 — Education~~
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- ~~75-03-16-29 — Buildings, Grounds, and Equipment~~
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- ~~75-03-16-31 — Outcomes Data Collection~~
- ~~75-03-16-32 — Normalcy Activities~~
- ~~75-03-16-33 — [Reserved]~~

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75-03-16-35	[Reserved]
75-03-16-36	[Reserved]
75-03-16-37	[Reserved]
75-03-16-38	[Reserved]
75-03-16-39	[Reserved]
75-03-16-40	[Reserved]
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75-03-16-43	Eligibility for Endorsement to Operate Out-Based Program – Effect of Endorsement
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**CHAPTER 75-03-40**  
**LICENSING OF QUALIFIED RESIDENTIAL TREATMENT PROGRAM PROVIDERS**

Section

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### **75-03-40-01. Definitions.**

As used in this chapter:

1. "Accredited" means to be accredited and in good standing by an independent, not-for-profit organization approved by the department. Accreditation organizations preapproved include the commission on accreditation of rehabilitation facilities, the joint commission, or the council on accreditation. Any other accrediting bodies must be approved by the federal health and human service office before the department can consider approval.
2. "Aftercare" means followup support and services provided to a resident and family after discharge from a facility.
3. "Assessment" means the ongoing process of identifying and reviewing a resident and the resident's family's strengths and needs based upon input from the resident, the resident's family, and others, including community members and health professionals.
4. "Behavior management" means techniques, measures, interventions, and procedures applied in a systematic fashion to prevent or interrupt a resident's behavior and promotes positive behavioral or functional change fostering resident self-control.
5. "Care plan" or "case plan" means the plan developed by the child and family team that incorporates formal and informal services and supports into a comprehensive, integrated plan that, using the identified strengths of the resident and the resident's family, addresses the needs of the resident and the resident's family across life domains to support the resident and the resident's family to remain in or return to the community.
6. "Child and family team" means an advisory or recommending group in relation to the resident's case plan. The custodial agency and child and family team, led by the resident and the resident's family, shall work cooperatively through multiagency and multidisciplinary approaches to provide a wider variety of support services to the resident, the resident's family, and foster care provider to carry out the permanency goals for the case plan.
7. "Contracted service providers" means a person or entity under contract or agreement with the facility to provide services and supports to residents.
8. "Custodian" means a person, other than a parent or guardian, to whom legal custody of the resident has been given by court order.
9. "Employee" means an individual compensated by the facility to work in a part-time, full-time, intermittent, or seasonal capacity for the facility. This definition is not inclusive to contracted service providers who come onsite to conduct trainings, treatment groups, individual therapy, or other program services.
10. "Facility" means a qualified residential treatment program.
11. "Guardian" means a person who stands in loco parentis to a resident or court appointed pursuant to North Dakota Century Code chapters 30.1-27 or 30.1-28.
12. "License" means a facility that is either licensed by the department or approved by the department if the facility is located within a tribal jurisdiction.

13. "Mechanical restraint" means any device attached or adjacent to the resident's body that the resident may not easily remove which restricts freedom of movement or normal access to the resident's body.
14. "Nonemployee" means an individual who is not compensated by the facility, such as a volunteer or student intern providing a specific service under the supervision of an employee.
15. "Normalcy" means a resident's ability to easily engage in healthy and age or developmentally appropriate activities that promote the resident's well-being, such as participation in social, scholastic, and enrichment activities.
16. "Nurse" means a nurse licensed in accordance with North Dakota Century Code chapter 43-12.1.
17. "Outcomes" means the results to which all performance targets must contribute, describing specific states or conditions that change, and which are influenced by the achievement of performance targets.
18. "Overnight hours" means a consecutive eight-hour period of time designated as resident sleep hours defined by the facility.
19. "Personnel" means employees hired and nonemployees placed with or present in the facility.
20. "Qualified individual" means a trained professional or licensed clinician designated by the department to complete the assessment, which will assist in determining the resident's appropriate level of care.
21. "Reasonable and prudent parent standard" means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a resident while at the same time encouraging the emotional and developmental growth of the resident participating in extracurricular, enrichment, cultural, and social activities.
22. "Resident" means an individual under the age of twenty-one admitted to and residing in the facility.
23. "Restraint" means a personal restraint, mechanical restraint, or drug used as a restraint.
24. "Seclusion" means involuntarily confining a resident alone in a room or area where the resident is prevented from leaving. The immediate goal of seclusion is to defuse a dangerous situation, protect the resident and others from injury, and regain a safe and controlled environment.
25. "Trauma informed" is the services or programs to be provided to or on behalf of a resident and the resident's family under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma in accordance with recognized principles of a trauma informed approach and trauma specific interventions to address trauma's consequences and facilitate healing.
26. "Trauma informed treatment" means a treatment model designed to address the identified needs, including clinical needs as appropriate, of the resident with serious emotional or behavior disorders or disturbances and is able to implement the treatment identified for the child by the assessment completed by the qualified individual.
27. "Treatment" means the use of interventions that prevent or cure disease, reducing symptoms, and restoring the resident to the highest practical functional level.

28. "Treatment plan" means a plan created by the facility which delineates goals, objectives, and therapeutic interventions regarding the appropriate level of care based on the uniqueness of each resident, which considers the perspectives of the resident, the resident's clinical treatment team, family and significant others, which builds on the resident's strengths, and which incorporates a discharge focus.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-00.1, 50-11-03

#### **75-03-40-02. Effect of license.**

1. A facility license shall state the effective date. A license is effective for a maximum period of two years. A facility license is nontransferable and is valid only on the premises and for the number of residents indicated on the license.
2. For a licensed facility that changes its ownership or for a provisionally licensed facility upon issuance of an unrestricted license:
  - a. The initial period of licensure is one year; and
  - b. The licensing period thereafter may be renewed for a two-year period if the facility successfully remains in compliance with all licensing rules and requirements.
3. The department may issue a license without inspecting a facility's buildings, grounds, and equipment if the department finds:
  - a. The facility was inspected and complied with the provisions of this chapter and North Dakota Century Code chapter 50-11 regarding buildings, grounds, and equipment in the preceding year; and
  - b. The facility is otherwise eligible to receive a license.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-01, 50-11-02

#### **75-03-40-03. Application for license.**

1. Applicants must be accredited and in good standing with one of the department-approved national accreditation bodies.
2. A person may not apply for a license to operate a facility under this chapter until the department has reviewed the need for the additional residential placement resources. To enable the department to make a determination of need for a new qualified residential treatment program facility, the potential applicant shall submit an initial request for application, including the following documentation and information to the department:
  - a. A detailed plan for the operation of the proposed qualified residential treatment program which includes:
    - (1) The number, sex, and age range of the residents to be served;
    - (2) The needs or disabilities of residents to be served;



(3) The employee staffing, including a list of full-time and part-time positions by job titles and description;

(4) A description of the proposed program and treatment goals;

(5) A proposed budget; and

(6) The location of the facility and a drawing of the layout of the physical plant.

b. A detailed written description of the methodology and findings that document the reasons why the unserved children under subsection 2 may not be served satisfactorily in a less restrictive setting.

c. Data to support that existing qualified residential treatment program placement resources are not adequate to meet the needs of children who require the type or types of care, are North Dakota residents, and require the treatment services the applicant proposes to provide.

3. Upon receipt of initial request for application, the department shall:

a. Review the potential applicant's information and may ask for additional materials or information necessary for evaluation of need purposes;

b. Respond in writing within ninety days of receipt of all required information from the potential applicant;

c. Send written notice of determination of need. The notice must state the specific reason for the determination. If the department determines there is need for additional qualified residential treatment program beds, the notice must be accompanied by an authorization for the person to apply for a license to operate a new qualified residential treatment program; and

d. Inform the potential applicant of what is required to move forward with the application process.

4. An application for a facility license must be submitted to the department annually in the form and manner prescribed by the department.

5. The applicant shall carry general comprehensive liability insurance.

6. For purposes of time limits for approval or denial, an application is received by the department when all required information and documents have been received by the department. The department shall notify an applicant if an application is incomplete.

7. The department may declare an application withdrawn if an applicant fails to submit all required documentation within sixty days of notification.

8. An applicant currently holding a residential child care facilities license is exempt from compliance with subsection 2.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-01, 50-11-02, 50-11-03

#### **75-03-40-04. Correction orders.**

1. The following time periods are allowed for correction of violations of North Dakota Century Code chapter 50-11 or this chapter:
  - a. For a violation that requires an inspection by a state fire marshal or local fire department, five days;
  - b. For a violation that requires substantial remodeling, construction, or change to a building, sixty days; and
  - c. For all other violations, twenty days.
2. The department may require immediate correction of a violation that threatens the life or safety of a resident.
3. All time periods under this section commence on the third day after the department mails notice of the correction order to the facility.
4. Upon written request by the facility and upon showing need for an extension created by circumstances beyond the control of the facility and documentation that the facility has diligently pursued correction of the violation, the department may grant extensions of time to correct violations.
5. The department may inform the public of a facility correction order status.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02, 50-11-04.2

#### **75-03-40-05. Fiscal sanctions.**

1. The department may assess a fiscal sanction of twenty-five dollars per day for each day the facility remains out of compliance with a correction order.
2. The issuance of a fiscal sanction does not preclude the department's pursuit of other actions, including provisional licensure, injunction, and license revocation.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02, 50-11-04.4, 50-11-04.5

#### **75-03-40-06. Provisional license.**

1. A provisional license must state:
  - a. The facility has failed to comply with applicable standards and regulations of the department;
  - b. The areas of noncompliance noted by the department in a written document; and
  - c. An expiration date not to exceed one year from the date of issuance.

2. The department shall exchange a provisional license for an unrestricted license, upon the facility's demonstration of compliance, satisfactory to the department, with all applicable standards and regulations.
3. A provisional license may be issued only to a facility who has acknowledged, in writing, the factual and legal basis for the violation. If not acknowledged by the facility, the department may revoke a license in accordance with this chapter or North Dakota Century Code chapter 50-11.
4. Any provisional license must be accompanied by a written statement of violation signed by a designee of the department.
5. A facility with a provisional license is not eligible for foster care maintenance payments. The facility shall be eligible to receive foster care maintenance payments for only the period after which the department determines the facility is in full compliance with the applicable licensing standards and regulations.
6. Subject to the exceptions contained in this section, a provisional license entitles the facility to all the rights and privileges afforded a facility operating under an unrestricted license.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02.2

#### **75-03-40-07. Denial or revocation.**

1. A facility license may be denied or revoked under the terms and conditions of North Dakota Century Code chapter 50-11 or if the applicant or facility has violated any provision of North Dakota Century Code chapter 50-11 or fails to meet the minimum requirements of this chapter.
2. If the department decides to revoke a license, the department shall notify the facility in writing of its decision and the reasons for revocation. Upon receipt of notification arrangements shall be made by the facility in cooperation with each resident's custodian and parent or guardian for alternative placement.
3. A facility whose application for licensure has been revoked or denied may appeal to the department under the provisions of North Dakota Century Code sections 50-11-08 and 50-11-09. During an appeal, the facility may not have residents.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02, 50-11-07, 50-11-08, 50-11-09

#### **75-03-40-08. Residential bed capacity.**

1. A facility may not receive a licensing amendment to increase or decrease facility bed capacity without approval of the department.
2. To qualify for an increase or decrease, a facility shall:
  - a. Submit a written request;
  - b. Provide a rationale for bed capacity change; and

c. Be in compliance with North Dakota Century Code chapter 50-11 and this chapter.

3. The department shall review the facility's request and may approve or deny the request within fifteen working days after considering the need for the beds and the number of beds available. If accepted, the facility will receive an amended license.

4. The department has the authority to conduct a needs assessment at any time to determine the maximum number of licensed qualified residential treatment program beds required to meet the treatment needs of North Dakota children statewide. The needs assessment will allow the department to license facility beds accordingly. The department shall notify facility providers with a sixty-day notice of intent to increase or decrease bed capacity.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-02, 50-11-03, 50-11-09

**Law Implemented:** NDCC 25-03.2-03.1, 50-11-02.3

#### **75-03-40-09. Facility closure.**

The facility shall have a policy to ensure proper and efficient procedure in the event a facility would close. Prior to closing, the facility administrator shall provide at least a sixty-day written notice to the department:

1. Detailing a plan for closure, including:

a. Date of closure;

b. Plan to notify each resident's custodian and parent or guardian;

c. Identification of a North Dakota depository to maintain the facility's case, fiscal, employee, and nonemployee records; and

d. Retention of all fiscal records for a period of seven years following account settlement.

2. Written notification must be given at least forty-five days prior to closure for each resident's custodian and parent or guardian. Notification also shall be given to all former residents currently receiving aftercare services.

3. A facility that does not follow the closure standards may be subject to fiscal sanctions.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-10. Governance.**

1. Each facility shall have a governing body responsible for the operation, policies, activities, practice, and overall operations of the facility. The governing body shall:

a. Be composed of at least five members. A list of the names and contact information of members of the governing body must be maintained and submitted to the department annually. Each board member annually shall disclose conflicts of interest. Members of the board may not be family or have conflicts of interest with the facility administrator or employees with budget or accounting duties;

b. Meet at least every six months;

- c. Maintain records of the governing body's meetings;
  - d. Develop and review policies for member selection and rotation;
  - e. Ensure each member understands the facility operation and program goals;
  - f. Ensure the facility is funded, housed, staffed, and equipped in a manner required for the provision of services;
  - g. Provide financial statements and audits to the department for reimbursement purposes, upon request;
  - h. Ensure the facility has an active strategic plan with a schedule to review annually;
  - i. Employ a qualified facility administrator and delegate responsibility to that facility administrator for the administration of the facility;
  - j. Evaluate the performance of the facility administrator at least annually;
  - k. Adopt a written statement of the purpose and philosophy of the facility; and
  - l. Adopt written policies for the facility regarding administration, personnel, buildings, grounds, and program services. Personnel policies for the recruitment and retention of employees necessary to operate the facility must indicate expectations of employees and nonemployees, detail job descriptions for each position, and ensure a process to review policies and procedures with employee participation at least every three years.
2. All statements and policies required by this chapter must be in writing to demonstrate the intent of the standards are integrated into facility practice. The facility policy must be up to date.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-11. Disaster plan.**

A facility shall have a written disaster plan to accommodate emergencies. The disaster plan must allow the department or custodial agency to identify, locate, and ensure continuity of services to residents who are displaced or adversely affected by a disaster. The disaster plan must address how to accommodate accessibility needs for all residents and staff. The facility shall ensure the disaster plan specifies:

1. Where employees, nonemployees, and residents would go in an evacuation, including one location in the nearby area and one location out of the area;
2. Contact information inclusive of phone numbers and electronic mail addresses for facility administration;
3. A list of items the facility will take if evacuated, including any demographic and emergency contact information for each resident and medication and medical equipment to meet the needs of residents;
4. The process the facility will use to inform the department and each resident's custodian and parent or guardian if the resident is displaced or adversely affected by a disaster;

5. Employee training on the disaster plan must detail procedures for meeting disaster emergencies. The review of the disaster plan must occur with employees on an annual basis to ensure it is current, accurate, and employees understand their role. The facility shall document the annual review and provide the documentation to the department upon request;
6. Resident training on the disaster plan ensuring awareness of all emergency and evacuation procedures upon admission to the facility. These procedures must be reviewed upon intake into the facility and every quarter. Resident training must include the performance and documentation of fire evacuation drills;
7. The facility has telephones centrally located and readily available for use in each living unit of the facility. Emergency numbers must be written and posted by each telephone;
8. There must be at least two independent exits from every floor. The exits must be located so that residents can exit from each floor in two separate directions, without going through a furnace room, storage room, or other hazardous area; and
9. Flashlights must be available for emergency purposes.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11

**Law Implemented:** NDCC 50-11

#### **75-03-40-12. Quality assessment and performance improvement.**

A facility shall have a performance and quality improvement plan that advances efficient, effective service delivery, effective management practices, and the achievement of strategic and treatment program goals and outcomes.

1. A facility shall have a written performance and quality improvement plan that operationalizes the organization's performance and quality improvement system and:
  - a. Defines the organization's approach to quality improvement;
  - b. Defines employee roles and responsibility for implementing and coordinating the performance and quality improvement plan;
  - c. Identifies what is being measured;
  - d. Defines data collection processes and applicable time frames;
  - e. Outlines processes for reporting findings and monitoring results; and
  - f. Provides a document or chart that describes the organization's performance and quality improvement plan, including committees and members, as appropriate.
2. A facility performance and quality improvement plan must include guidelines for performance and outcomes which identify measures to build organizational capacity, improve services, and meet licensing, contracting, and reporting requirements, by evaluating the:
  - a. Impact of services on resident outcomes;
  - b. Quality of service delivery; and
  - c. Management and operations performance.

3. A facility shall use a department-approved standardized tool to measure resident outcomes approved by the department and in compliance with national accreditation standards.
4. A facility shall conduct the department-approved postresidential outcomes survey at the conclusion of the six-month required followup aftercare period.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

### **75-03-40-13. Personnel files.**

1. The facility shall maintain an individual file on each employee. The file must include:
  - a. File inventory detailing first and last date of employment, reason employment ended, training totals per year, and performance evaluation dates due;
  - b. The application for employment including a record of previous employment;
  - c. A job description specifying the employee's roles and responsibilities;
  - d. A statement signed by the employee acknowledging the confidentiality policy;
  - e. Documentation of information obtained from an employee's references if previously employed at another residential facility;
  - f. Annual performance evaluations;
  - g. Professional development and training records consisting of the name of presenter, date of presentation, topic of presentation, and length of presentation. The following training must be completed and required training certificates placed in the employee file:
    - (1) First-aid training;
    - (2) Cardiopulmonary resuscitation and automated external defibrillator; and
    - (3) Nonviolent crisis intervention;
  - h. Evidence of the employee having read and received a copy of the law and facility procedures requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, initially upon hire and annually thereafter;
  - i. Results of fingerprint-based criminal background checks, motor vehicle operator's license record, as applicable, and child abuse or neglect record;
  - j. Any other evaluation or background check deemed necessary by the facility administrator of the facility; and
  - k. Verification of any required license or qualification for the position or tasks assigned to the employee.
2. The facility shall maintain an individual file on each nonemployee. The file must include:
  - a. Personal identification information;
  - b. Results of fingerprint-based criminal background checks, motor vehicle operator's license record, as applicable, and child abuse or neglect record;



c. Description of duties;

d. Orientation and training records consisting of name of presenter, date of presentation, topic of presentation, and length of presentation; and

e. Evidence of the nonemployee having read and received a copy of the law and facility procedures requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, initially upon hire and annually thereafter.

3. The facility shall adopt a policy regarding the retention of employee and nonemployee files.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-14. Facility administrator.**

The governing body of the facility shall designate a facility administrator for the facility.

1. The governing body of the facility shall clearly define, in writing, the responsibilities of the facility administrator. If the facility is licensed for ten or more residents, the facility shall employ a full-time onsite facility administrator. A facility may not employ a facility administrator less than half-time.

2. The facility administrator must have a bachelor's degree in business or public administration, social work, behavioral science, or a human services field and have four years of related work experience in administration or must be an individual otherwise qualified and employed as a residential child care facility administrator prior to October 1, 2019.

3. The facility administrator shall assure adequate supervision is provided to all employees and nonemployees working or placed in the facility.

4. The facility administrator shall designate and provide evidence of the designation in the employee's file, at least one employee authorized to apply the reasonable and prudent parent standard. The designated employee shall receive training on how to use and apply the reasonable and prudent parent standard.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-15. Clinical director.**

1. The facility shall clearly define, in writing, the responsibilities of the clinical director. The duties of the clinical director must be devoted to the provision of clinical services.

2. The clinical director must have a master's degree in a behavioral science field and must be licensed as required by the field of practice, with three years of work experience in a clinical setting, have experience working with children in need of treatment, and provide evidence of supervisory knowledge and skills, or must be an individual otherwise qualified and employed as a residential child care facility program director prior to October 1, 2019.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03



**Law Implemented:** NDCC 50-11-02

**75-03-40-16. Treatment coordinator.**

1. The facility clearly shall define, in writing, the responsibilities of the treatment coordinator employees. The duties of a treatment coordinator employee must be devoted to the coordination of treatment services and overall case management of treatment planning for residents. A treatment coordinator employee must have achieved the competencies necessary to implement an individualized care plan for each resident.
2. The treatment coordinator employee must have a bachelor's degree in a behavioral science field and must be licensed as required by the field of practice, and two years previous paid or unpaid work experience with children or families or be an individual otherwise qualified and employed as a residential child care facility social service employee prior to October 1, 2019.
3. A facility shall have sufficient treatment coordinator employees employed to meet minimum employee-to-resident ratios required by this chapter.
4. A treatment coordinator employee is responsible for the supervision of other employees or nonemployees and must be allowed reasonable time to perform supervision tasks.
5. The professional development and training records must document the treatment coordinator employee has had appropriate training to coordinate treatment services and trauma informed care.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

**75-03-40-17. Direct care employees.**

1. The facility clearly shall define, in writing, the duties and responsibilities of the direct care employees.
2. All direct care employees must:
  - a. Be at least twenty-one years of age;
  - b. Have a high school diploma or equivalent;
  - c. Have at least one year of experience working with children or families. If a prospective direct care employee does not have one year of experience working with children or families, the facility may choose to hire, but then shall provide shadowing and supervision to the direct care employee for up to one year or until the direct care employee has successfully completed all required training noted in section 75-03-40-29; or
  - d. An individual otherwise qualified and employed as a residential child care facility direct care employee prior to October 1, 2019.
3. A direct care employee shall complete mental health technician certification.

4. A direct care employee supervising other direct care employees must have a bachelor's degree in a behavioral science field or two years previous work experience with children or families.
5. A facility always shall have direct care employees working to meet the minimum employee-to-resident ratios required by this chapter.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-18. Nurse.**

1. The facility clearly shall define, in writing, the duties and responsibilities of the nurse which must be within the scope of North Dakota Century Code chapter 43-12.1.
2. A facility shall provide for an onsite nurse to accommodate the medical needs of residents.
3. The nursing employee may be an employee of the facility or a contracted provider available to provide onsite nursing services to residents.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-19. Family engagement specialist.**

1. The facility clearly shall define, in writing, the responsibilities of family engagement specialists. The duties of the family engagement specialist must be devoted to the provision of family engagement and aftercare service supports to best meet the needs of the resident and the resident's family. The family engagement specialist shall maintain ongoing contact with the resident's family as a liaison to the resident's treatment in the facility. Tasks may include:
  - a. Communicating with the resident's family throughout the week to update the family on the resident's day, treatment progress, and challenges;
  - b. Offering support to the treatment coordinator employee and the resident's treatment plan; and
  - c. Providing or coordinating aftercare services and supports.
2. A family engagement specialist must have achieved the competencies necessary to implement family engagement strategies while the resident is in placement and coordinate an aftercare plan for no less than six months postdischarge.
3. The family engagement specialists must have a bachelor's degree in a behavioral science field and must be licensed as required by the field of practice, and two years previous paid or unpaid work experience with children or families or be an individual otherwise qualified and employed as a residential child care facility social service employee prior to October 1, 2019. A higher degree may substitute for years of experience or the prospective family engagement specialist shall achieve the certification in either peer or family support and have the competencies to engage with families.

4. A facility shall have sufficient family engagement specialists to meet the needs of the residents and family during placement and for no less than six months postdischarge.
5. The professional development and training records must document the family engagement specialist has had appropriate training to coordinate treatment services, including family engagement and trauma informed treatment.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-20. Contracted service providers.**

A facility may contract for or otherwise arrange professional services not provided by the facility when necessary for implementation of a resident's treatment plan. If a facility does contract for professional service providers to offer treatment onsite, the facility shall:

1. Maintain a list of all contracted service providers offering services onsite;
2. Require each contracted service provider to have the appropriate North Dakota license or certification; and
3. Require each contracted service provider to submit written reports to the facility on the resident's treatment progress.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-21. Nonemployees.**

1. A facility that uses nonemployees shall:
  - a. Develop and provide a copy of a description of duties and specified responsibilities;
  - b. Designate an employee to supervise and evaluate nonemployees; and
  - c. Develop a plan for the orientation and training of nonemployees to include the philosophy of the facility and the needs of the residents and the residents' families.
2. Nonemployees may provide services in support of, but not in substitution for, employees. Nonemployees may not be counted as an employee for purposes of employee-to-resident ratio requirements imposed by this chapter.
3. Nonemployees shall create records of incidents that occur during their presence at the facility to the same extent employees are required to create such records.
4. Nonemployees shall comply with section 75-03-40-23.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

### **75-03-40-22. Personnel policies.**

The facility shall identify to the department all employee and nonemployee positions, using the titles and duties described in this chapter. For purposes of internal operations, a facility may use any definition or title for its positions. All employees and nonemployees must be capable of performing assigned duties. The facility shall have clearly written personnel policies for employees and when applicable, nonemployees. The facility shall make the policies available to each employee and nonemployee. The policies must include:

1. An annual professional training and development plan for all positions;
2. Procedures for reporting suspected child abuse and neglect;
3. Procedures detailing employee supervision and the number of employees one supervisor can supervise. The facility shall require and document annual training for supervisors to maintain and improve competence in the supervisory role and in facility treatment practices;
4. Procedures for employee annual written evaluation;
5. Procedures for employee and nonemployee disciplinary actions and terminations;
6. Procedures for storing personal belongings which may include car keys, cell phones, and employee or nonemployee medication while on duty;
7. Procedures for personnel grievances;
8. Each facility shall implement policy and procedure to address:
  - a. Zero tolerance policies, which must include zero tolerance for sexual abuse and sexual harassment by employees and nonemployees to others in the facility;
  - b. Nondiscrimination against an employee or nonemployee; and
  - c. Steps taken when an employee or nonemployee violates policy, procedures, or licensing standards that affects the mental or physical well-being of a resident; and
9. A plan for review of the personnel policies and practices with employee participation at least once every three years, or more often as necessary. The facility shall document policy reviews, revisions, and employee participants in writing.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

### **75-03-40-23. Confidentiality.**

1. For purposes of this section, "persons who have a definite interest in the well-being of the residents" include:
  - a. The resident's custodian, parent, or guardian, except to the extent the parental rights have been terminated or limited by court order;
  - b. The referring agency that placed a resident in the facility; and
  - c. An individual or entity identified as a provider of services, as determined by the department, located in the home community of the resident's family, for the purposes of reunification.

2. Except as otherwise provided in this section, facility records concerning residents who have received, are receiving, or seek to receive facility services must be safeguarded and may be made available only:
  - a. To employees and nonemployees of the facility, to the extent reasonably necessary for the performance of their duties;
  - b. To persons authorized by a custodian, parent, or guardian who may lawfully review a resident's records, to review or receive copies of that resident's records;
  - c. In a judicial proceeding;
  - d. To officers of the law or other legally constituted boards and agencies; or
  - e. To persons who have a definite interest in the well-being of the residents concerned, who are in a position to serve their interests, and who need to know the contents of the records to assure their well-being and interests.
3. A facility may not make public or otherwise disclose by electronic, print, or other media for fundraising, publicity, or illustrative purposes, any image or identifying information concerning any current resident or former resident receiving aftercare services or the family of the resident, without first securing the written consent of the custodian and parent or guardian of the resident, or the written consent of an adult who was a former resident of the facility. The facility shall:
  - a. Ensure the written consent is informative, including full disclosure of how the image or information will be used, including any future use, and specifically must identify the image or information that may be disclosed by reference to dates, locations, and other event-specific information;
  - b. Inform the person signing that the individual is free to either grant or refuse to grant consent;
  - c. Provide a seven-day waiting period during which the consent may be withdrawn by the signing party; and
  - d. Ensure the consent is time-limited. The written consent must apply to an event that occurs no later than one year from the date the consent was signed.
4. A facility shall disclose its records to the department as requested.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-06-15, 50-11-02, 50-11-05

#### **75-03-40-24. Child abuse and neglect.**

1. Upon hire and annually thereafter, all employees and nonemployees shall certify having read the law requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, and having read and received a copy of the facility's written child abuse and neglect procedures.
2. Each facility shall adopt written policies and procedures requiring employees and nonemployees to report cases of suspected child abuse or neglect. The procedures must include the following statement: "All employees and nonemployees will comply with North Dakota Century Code Chapter 50-25.1, child abuse and neglect. Therefore, it is the policy of this facility that if any employee or nonemployee who knows or reasonably suspects that a

current resident or former resident receiving aftercare services whose health or welfare has been, or appears to have been, harmed as a result of abuse or neglect, that employee or nonemployee immediately shall report this information to the department. Failure to report this information in the prescribed manner constitutes grounds for dismissal from employment or placement of nonemployee and referral of the employee or nonemployee to the office of the state's attorney for investigation of possible criminal violation."

3. The facility's policies and procedures must describe:

a. To whom a report is made;

b. When a report must be made;

c. The contents of the report;

d. The responsibility of each individual in the reporting chain;

e. The status and discipline of an employee or nonemployee who fails to report suspected child abuse or neglect; and

f. The status of the employee or nonemployee while the report is being assessed; if they are the subject of the report.

4. The facility shall cooperate fully with the department throughout the course of any assessment of any allegation of child abuse or neglect made concerning care furnished to a resident. The facility, at a minimum, shall provide the assessors with all documents and records available to the facility and reasonably relevant to the assessment and permit confidential interviews with employees, nonemployees, and residents. Internal facility interviews and investigations are not permitted to occur concurrent with a department assessment or law enforcement investigation.

5. In the case of an indicated determination, the facility shall notify the department licensing administrator, in writing, of the corrective action the facility has taken, or plans to take, to comply with any resulting recommendations from the institutional child protection team. The facility shall make assurances that revised facility practice will reduce the risk of the incident reoccurring. The facility shall respond within thirty days of receiving written notification of the finding.

6. A facility shall establish written policies specific to how the facility will proceed when a current or former employee or nonemployee is known to be:

a. Involved in any capacity in a reported incident of institutional child abuse or neglect; or

b. The subject of a services required decision in a child abuse or neglect report that occurred outside of the facility.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02, 50-25.1-03

### **75-03-40-25. Criminal conviction - Effect on operation of facility or employment by facility.**

1. A facility administrator may not be, and a facility may not employ or place, in any capacity that involves or permits contact between an employee or nonemployee and any resident cared for by the facility, an individual who is known to have been found guilty of, pled guilty to, or pled no contest to:

- a. An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-17, assaults - threats - coercion - harassment; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-20-12.3, sexual extortion; 12.1-22-01, robbery; or 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 12.1-31-07, endangering an eligible adult - penalty; 12.1-31-07.1, exploitation of an eligible adult - penalty; 14-09-22, abuse of child; or 14-09-22.1, neglect of child;
  - b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or
  - c. An offense, other than an offense identified in subdivision a or b, if the department determines the individual has not been sufficiently rehabilitated.
    - (1) The department may not consider a claim that the individual has been sufficiently rehabilitated until any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, has elapsed.
    - (2) An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction, is prima facie evidence of sufficient rehabilitation.
2. The department has determined the offenses enumerated in subdivisions a and b of subsection 1 have a direct bearing on the individual's ability to serve the public in a capacity involving the provision of care to children.
  3. In the case of a misdemeanor simple assault described in North Dakota Century Code section 12.1-17-01, or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction. The department may not be compelled to make such determination.
  4. The department may discontinue processing a request for a criminal background check for any individual who provides false or misleading information about the individual's criminal history.
  5. An individual is known to have been found guilty of, pled guilty to, or pled no contest to an offense when it is:
    - a. Common knowledge in the community verified by source documents;
    - b. Acknowledged by the individual; or
    - c. Discovered by the facility, authorized agent, or department as a result of a background check.



6. A facility shall establish written policies and engage in practices that conform to those policies to effectively implement this section, North Dakota Century Code section 50-11-06.8, and subsection 4 of North Dakota Century Code section 50-11-07.
7. A facility shall establish written policies specific to how the facility shall proceed if a current employee or nonemployee is known to have been found guilty of, pled guilty to, or pled no contest to an offense.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02, 50-11-06.8

#### **75-03-40-26. Background checks.**

1. The facility shall require a fingerprint-based criminal background check and child abuse and neglect index check be completed for each employee and nonemployee.
2. The facility shall make an offer of employment to an employee or an offer of placement to a nonemployee conditional upon the individual's consent to complete required background checks. While awaiting the results of the required background check, a facility may choose to provide training and orientation to an employee or nonemployee. However, until the approved background check results are placed in the employee or nonemployee file, the employee or nonemployee only may have supervised interaction with residents.
3. The facility shall submit proper paperwork for the department to perform an annual child abuse and neglect index check on every employee and nonemployee. The facility shall place a copy of the results in each employee or nonemployee file.
4. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department may conduct a nationwide name-based criminal history record investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background check.
5. The facility previously licensed as a residential child care facility until September 30, 2019, may use the current employee's or nonemployee's fingerprint-based criminal background check results in the personnel file previously completed by the residential child care facility to comply with this section.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02, 50-11-06.8

#### **75-03-40-27. Personnel health requirements.**

1. All employees and nonemployees must be capable of performing assigned tasks.
2. All employees shall undergo an initial health screening, performed by or under the supervision of a physician not more than one year prior to or thirty days after employment to verify good physical health to work in the facility. The professional performing the screening shall sign a report indicating the presence of any health condition that would create a hazard to others in the facility.



3. All employees and nonemployees shall undergo an initial test or screening for tuberculosis, within thirty days after employment or placement, and test results placed in employee and nonemployee files within thirty days of employment.
4. Unless effective measures are taken to prevent transmission, each facility shall develop a policy addressing that an employee or nonemployee suffering from a serious communicable disease must be isolated from other employees, nonemployees, and residents who have not been infected.
5. The facility shall develop a policy regarding health requirements for employees and nonemployees, including how often health screenings and tuberculosis testing will be required by the facility following the initial screening requirements.
6. The facility shall develop a policy requiring all employees and nonemployees to have the ability to carry out their assigned functions and duties. Employees or nonemployees whose condition gives reasonable concern for safety of residents may not be in contact with residents in placement.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-28. Minimum employee requirements.**

1. For purposes of this section:
  - a. "Reside" means to sleep and keep personal belongings; and
  - b. "Structure" means a building that is or may be free standing. The existence of a walkway, tunnel, or other connecting device on, above, or below ground is not effective to make one structure from two or more component structures.
2. Each facility shall adopt a policy specific to employee coverage for facility operations, including holidays, weekends, on-call clinical team rotations, daytime and overnight hours. Policy must address:
  - a. Designated employees required for the facility on-call clinical team;
  - b. Number of qualified employees onsite to sufficiently meet the needs of residents and respond to emergency situations;
  - c. Evaluation of the number of employees necessary to meet the age, developmental level, length of treatment, and the service needs of the resident population;
  - d. Ability to schedule same gender or cross gender supervision if indicated by resident treatment needs; and
  - e. Employees hired specific to the onsite educational program may not be counted as direct care employees, treatment coordinator employee, family engagement specialist, facility administrator, or a clinical director during any time educational services are provided.
3. Each facility that operates more than one structure in which residents reside shall count the total number of residents admitted to the facility, residing in all structures collectively for purposes of determining the required number of clinical and treatment employees to meet employee-to-resident ratios.

4. Each facility shall comply with the following minimum employee-to-resident ratio requirements:
  - a. A rotating on-call clinical team must be available twenty-four hours a day, seven days a week to meet the needs of resident emergency and crisis situations. The on-call clinical team must include at a minimum one nurse and one clinical employee;
  - b. No less than one half-time facility administrator for a facility providing treatment for up to nine residents;
  - c. No less than one full-time facility administrator for a facility providing treatment for ten or more residents;
  - d. No less than one full-time clinical director;
  - e. No less than one full-time nurse;
  - f. No less than one full-time treatment coordinator employee for each ten residents; and
  - g. No less than one full-time family engagement specialist for each eighteen residents or aftercare clients.
5. During awake hours each facility shall have no fewer than two employees qualified to provide direct care working on the property with at least one direct care employee on duty for each six residents.
6. During overnight hours each facility shall have:
  - a. Awake employees at all times;
  - b. No fewer than two employees qualified to provide direct care working on the property with at least one direct care employee on duty for each ten residents; and
  - c. A policy that includes a requirement that an employee will check on residents during overnight hours at a minimum of every fifteen minutes, and more frequently if the acuity of the resident demands greater supervision. The overnight checks must be conducted in the least invasive manner to not disrupt the residents.
7. The facility shall notify the department, in writing, if the minimum employee-to-resident ratios are not met based on position vacancies. An interim plan to cover the employee duties must be approved by the department.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-29. Employee professional development.**

1. All employees in contact with residents shall receive at least twenty hours of training per year, with evidence of completion in the employee file.
2. Required trainings to prepare employees to meet the needs of residents served by the facility include:
  - a. Certified first aid;
  - b. Certified cardiopulmonary resuscitation and automated external defibrillator training;

- c. Certified nonviolent crisis intervention training;
- d. Mental health technician training for direct care employees;
- e. Facility trauma informed care training;
- f. Child abuse and neglect mandated reporter training;
- g. Children's emotional and developmental needs; and
- h. Suicide prevention training, including identification of signs and facility response measures.

3. A certified instructor shall provide training for nonviolent crisis intervention, first aid, cardiopulmonary resuscitation, and automated external defibrillator. A formal certificate must be provided to each employee demonstrating their competencies in the specific training area. A copy of the certificate must be placed in the employee file. Until a new employee has completed these required trainings, the facility administrator shall ensure that another employee, current in the required trainings, is scheduled to work on the same shift as the new employee pending training.

4. Prior to a new employee working independently with residents, the facility shall provide orientation training to the employee covering all of the following areas, with evidence of completion present in the employee file:

- a. Overall facility philosophy and program goals;
- b. Review of administrative procedures, policy, and protocols;
- c. Review of personnel policies;
- d. Review of programs and services, policy, and protocols;
- e. Discuss the nature of residents' emotional and physical needs;
- f. Discuss the expected employee conduct toward residents, expected resident conduct, and the facility's behavior management techniques;
- g. Provide an overview of trauma and facility trauma informed treatment;
- h. Review protocol for observing and reporting resident behavior;
- i. Review resident rights and grievance procedures;
- j. Identification and reporting of child abuse and neglect;
- k. Review suicide prevention;
- l. Review disaster planning and evacuation procedures;
- m. Resident search procedures and policies;
- n. Review confidentiality standards;
- o. Review facility procedures for reporting a runaway;
- p. Fire safety and evacuation procedures;

- q. Emergency medical procedures and facility emergency security measures and procedures;
- r. Discuss interest in becoming certified for medication distribution; and
- s. Review facility daily routine, activities, cleaning, transportation, treatment group schedules, and meals.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-30. Resident file.**

1. Upon placement, a resident's case record is confidential and must be protected from unauthorized examination unless permitted or required by law or regulation. The facility shall adopt a policy regarding the retention of resident records.
2. The resident record must include on file:
  - a. A file inventory with dates of admission, discharge, aftercare, referral source, and emergency contact information;
  - b. The resident's full name, date of birth, and other identifying information;
  - c. A photo of the resident;
  - d. The name and contact information of a resident's custodian and parent or guardian at the time of admission, as well as contact information of additional family members approved to engage in visitation and maintain family connections;
  - e. The date the resident was admitted and the referral source;
  - f. Signed care agreement or contract, including financial responsibility and expectations of all parties. The placement agreement must indicate a clear division of responsibility and authority between the facility and the custodian and parent or guardian;
  - g. Signed written consents, as applicable;
  - h. A copy of the initial and all ongoing assessment reports completed by the department approved qualified individual or if the resident is placed for thirty-day assessment period, documentation indicating the resident is placed for assessment must be on file;
  - i. A copy of required interstate compact forms, as applicable;
  - j. If the resident is in public custody, a current court order establishing the placement authority of a public agency;
  - k. If the resident is in public custody, a copy of initial and any ongoing judicial reviews granting approval for the qualified residential treatment program placement;
  - l. If the resident is in public custody, a copy of the quarterly child and family team meeting notes or foster care case plan must be in the resident's file;
  - m. Progress reports must be provided to the resident, custodian and parent or guardian monthly, or upon request. This must include progress reports from an outside agency or professional providing services to the resident outside of the facility;

n. Ongoing documentation and case activity logs detailing progress;

o. Documentation of discharge planning;

p. Visitation records. The facility shall have a formal plan for visitation signed by the custodian and parent or guardian detailing opportunities for the resident to engage in onsite visitation and home visits with family;

q. Education records;

r. All incident reports involving the resident; and

s. Documentation the clinical director, facility administrator, or designated employee has reviewed the resident case record monthly.

3. Resident medical information, including:

a. Consent for medical care. The facility has obtained written, signed informed consent that gives the facility, resident's physician, or health care consultant the following authority to:

(1) Provide or order routine medical services and procedures;

(2) Delegate and supervise administration of medications by authorized employees and for such employees to handle, provide the medication to the resident, and provide monitoring of resident self-administration;

(3) Obtain medical information, as needed, on the resident; and

(4) Provide or obtain an order for medical services and procedures when there is a life-threatening situation, emergency medical procedures, including surgery, when it is not possible to reach the person or authority authorized immediately to give signed written specific informed consent;

b. Documentation about any special nutritional or dietary needs identified;

c. Documentation of health history;

d. Documentation of any medical treatments received while residing in the facility, including:

(1) Dates and person administering medical treatment;

(2) Immunizations;

(3) Laboratory tests;

(4) Routine and emergency health care examinations;

(5) Dental examinations and treatment; and

(6) Eye examinations and treatment;

e. Medication administration records; and

f. A copy of the treatment plan prepared by the facility.

4. The resident record must include aftercare supports for six months postdischarge. Information to include:

- a. Contact information for the custodian and parent or guardian and others determined necessary for aftercare;
- b. Date of discharge and six-month aftercare date of completion;
- c. Documentation from the family engagement specialist detailing the aftercare or family treatment plan progress;
- d. Documentation of ongoing communication with the resident, resident's custodian and parent or guardian, and local providers; and
- e. Upon six-month completion of aftercare, the resident file must include:
  - (1) Summary of the six-month aftercare services provided; and
  - (2) A copy of the department-approved outcomes survey.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02, 50-11-05

#### **75-03-40-31. Programs and services.**

Facility shall utilize trauma informed treatment and shall adopt a plan for the model which must include a description of services offered to residents and their families. The facility shall clearly state which services are provided directly by the facility and which services must be provided in cooperation with community resources, such as public or private schools, nursing, psychological, psychiatric, clinical services, and other appropriate services.

1. The facility shall have the ability to provide resource information for referral sources; including:
  - a. Identification of the treatment services provided;
  - b. Characteristics, including specific diagnoses, of children appropriate for referral and admission to the facility;
  - c. Trauma informed care model used;
  - d. The process by which the facility intends to achieve its goals;
  - e. Treatment orientation of the facility;
  - f. Information required with the referral;
  - g. Specialty programs offered by the facility;
  - h. Performance quality improvement data;
  - i. Education options available to residents;
  - j. Exclusions of residents the facility is unable to serve, if applicable; and
  - k. Other information as needed to assist with determining appropriate level of care for a resident to be placed in the facility.
2. Education. Any primary or secondary education program offered by a facility must be in compliance with standards established by the department of public instruction. The facility

shall ensure all residents who receive care in the facility comply with all state school attendance laws.

3. Religious opportunities. The facility shall make a reasonable effort to make opportunities available for residents to attend religious ceremonies within the area in which the facility is located, giving appropriate consideration to any requests by the resident and the resident's family. The facility shall respect the religious beliefs of the resident and the resident's family.
4. Normalcy activities. The facility shall document the resident's normalcy activities and share the information with the resident's custodian and parent or guardian. Each facility shall create a written policy detailing:
  - a. The employee job description related to carrying out the duties of the reasonable and prudent parent standard;
  - b. The variety of normalcy activities offered on and offsite to residents; and
  - c. Procedures identifying supervision, transportation, and offsite activity emergency responses.
5. The facility shall develop policy specific to grievance procedures to allow residents and their families, referral sources, and stakeholders to submit complaints and grievances to the facility regarding programs and services. The facility shall have a policy in place to review and respond to the complaints and grievances. The facility shall maintain an annual record of complaints, grievances, and resolutions.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

### **75-03-40-32. Respite.**

A facility may operate an optional respite care program with approval of the department. Respite care is defined as temporary relief care for a child with special medical, emotional, or behavioral needs, which requires time-limited supervision and care by a licensed foster care provider. A respite care episode is a specified period of time during which respite care is provided by a licensed provider.

1. Eligibility. Residents eligible for respite care offered by an approved facility include a foster child in public custody and a former qualified residential treatment program resident engaged in the six-month aftercare.
2. Admission and discharge. A facility operating a respite care program shall have the written policies and procedures for admissions and discharge for respite care, including eligibility into the respite program, admissions criteria, required belongings, medications needed upon admission, required identification documentation, authorizations needed, written consents for emergency medical care, medications, and discharge planning.
3. Staffing. A facility shall assign an employee to have primary responsibility for the facility's respite care program. Employee-to-resident ratios at a minimum, must meet the ratio as described in this chapter for direct care.
4. Program and services. A facility respite program must be developed which allows for a short-term refocus of service delivery and supports for a community placement. Respite care placements are exempt from the medical examination requirements due to the short period of stay.



5. Respite care plan. A facility shall develop an abbreviated plan for each resident admitted to the facility for respite care. The abbreviated plan must provide for services to meet social, emotional, medical, and dietary needs. The respite plan must address daily routine, engagement in recreational activities, ongoing education, and discharge planning. The respite plan may include a list of facility-based and community-based services and supports the resident and family is currently receiving or will receive upon discharge.
6. Length of stay. A respite care placement may not extend beyond seven days per episode.
7. Discharge. When a resident is discharged from respite care, the facility shall document in the resident's respite file the dates of the resident's stay, a summary of the resident's stay, the name of the person to whom the resident was discharged, and a list of all personal belongings and medications that went with the resident upon discharge. A final plan must be provided to the custodian and parent or guardian upon discharge.
8. Respite resident file. A facility with a respite care program shall include:
  - a. The resident's full name, date of birth, and other identifying information;
  - b. The contact information of the resident's custodian and parent or guardian at the time of admission;
  - c. The date the resident was admitted and discharged;
  - d. Signed respite care agreement;
  - e. Signed written consents, including consent to nonemergency use of psychotropic medication and consent for use of secured unit, if applicable;
  - f. If the child is in public custody, a current court order establishing the facility's authority to accept and care for any resident under the custody of a public agency;
  - g. Copy of the abbreviated plan prepared by the facility; and
  - h. Medication administration records, if applicable.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

### **75-03-40-33. Admissions and assessment.**

1. Admissions policies and procedures. A facility shall have written resident admission policies and procedures that describe the primary treatment offered onsite, range of presenting behaviors the facility shall treat, and procedures for admitting a resident.
2. Admissions and discharge committee. A facility shall have an admissions and discharge committee with written policy specific to employees on the committee, how often the committee meets, and the timeliness the committee has in responding to referrals. The committee shall meet on at least a weekly basis. Before a prospective resident is admitted to the facility, the committee shall evaluate the needs of the prospective resident using information and procedures described in policy and determine whether the facility can meet the identified needs of the prospective resident.
3. Admission determination. The admissions committee shall complete a written, dated, and signed admission determination on a prospective resident which includes a preadmission



review and identification of the prospective resident's primary presenting needs. The committee shall provide a written statement recommending reasons for or against admission based on the ability of the facility to meet the prospective resident's needs. The facility shall provide the determination and decision to the referral within seven days of receipt of the completed application. Referral may be completed by:

a. A public agency, if a prospective resident is in foster care and a public agency is granted custody and given full placement authority pursuant to law or court order; or

b. A parent or guardian, if a prospective resident is a private placement.

4. Preplacement visit. Whenever possible, a facility shall arrange with the custodial agency for a preplacement visit for the prospective resident and the parent or guardian, to provide them with an orientation to the facility. If the ability to arrange onsite visitation is not possible, a virtual meeting is acceptable.

5. Admission conditions. A facility may admit a prospective resident if the facility can meet the prospective resident's needs, as determined by the admission determination and the following conditions are met:

a. Qualified individual - Level of care assessment.

(1) Completed assessment. The facility has received documentation from the department-approved qualified individual granting approval for the resident to be admitted to a qualified residential treatment program based on the North Dakota level of care assessment; or

(2) Thirty-day assessment period approval. The facility has received documentation from the department-approved qualified individual granting approval for the resident to be admitted for a thirty-day assessment period. A resident may not be admitted to the facility for the assessment period without the approval of the qualified individual. For residents placed in the facility during the thirty-day assessment period to determine appropriateness of a qualified residential treatment program placement, the facility shall allow access to the qualified individual and collaborate in the completion of the level of care assessment;

b. Juvenile court approval. For foster children, confirmation from the juvenile court must be on file approving the qualified residential treatment program placement within sixty days of the resident's date of entry into the facility;

c. Interstate placements. In accepting a prospective resident from outside the state of North Dakota, the facility shall receive prior written approval under the interstate compact on the placement of children;

d. Nondiscrimination against a resident; and

e. All documentation required for the resident record, including medical consent, medical history, family contact information, family history, placement care agreement, and financial responsibility.

6. Orientation. Upon admissions, each resident shall receive orientation to facility living. An employee shall:

a. Orient the new resident and the resident's custodian and parent or guardian to the facility program, if no preplacement visit occurred;

b. Help the new resident to adjust to the effects of separation from family and to the residential placement; and

c. Provide the new resident and the resident's custodian and parent or guardian copies of the house rules, including rules on visiting, expected behavior and consequences for rule infractions, resident rights, and grievance and complaint procedures, with explanations of the documents.

7. Initial screenings. Upon admissions, a facility shall complete for each resident a:

a. Suicide risk screening within twenty-four hours;

b. Mental health screening within twenty-four hours; and

c. Health screening completed by the facility nurse within twenty-four hours.

8. Discharge date. Each admission must have preliminary plans for discharge.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-34. Interstate compact on the placement of children.**

1. All placements of children made from out-of-state must follow the interstate compact on the placement of children or the interstate compact on juveniles and be in full compliance with the appropriate interstate compact. It is the responsibility of the facility to ensure, prior to the placement in the facility, all necessary procedures pursuant to the interstate compact on the placement of children or the interstate compact on juveniles have been completed.

2. Before admitting an out-of-state resident, a facility shall make arrangement with the referral to assure a lawful return of the resident to the sending state without regard to the circumstance under which the resident is discharged.

3. Out-of-state referrals must adhere to all requirements of this chapter.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 14-13, 27-22

#### **75-03-40-35. Treatment plan.**

1. A treatment coordinator shall develop a written, individualized treatment plan for each resident. Upon admission, the facility shall conduct an initial assessment of the resident's treatment and service needs and develop a treatment plan. An initial abbreviated treatment plan should be developed immediately for each resident while the formal treatment plan is developed by utilizing the needs assessments and other collateral information within fourteen days. The resident's treatment plan must:

a. Indicate review of the level of care assessment completed by the qualified individual, as well as other supporting documentation to assist in the development of a written treatment plan;

- b. Be based on a thorough assessment of the situation and circumstances of the resident and the resident's family strengths and needs;
- c. Support timely achievement of permanency, including reunification, guardianship, or adoption, if in foster care;
- d. Specify details, including the resident's:
  - (1) Strengths and needs;
  - (2) Family's strengths and needs;
  - (3) Behavioral functioning;
  - (4) Psychological or emotional adjustment;
  - (5) Personal and social development;
  - (6) Medical needs;
  - (7) Medication management;
  - (8) Educational and vocational needs;
  - (9) Independent living and transition skills; and
  - (10) Recreational interests and normalcy activities;
- e. Be time-limited, goal-oriented, and individualized to meet the specific needs of the resident as identified from the assessment, including:
  - (1) Implementation date;
  - (2) Goals and objectives that specify behaviors to be modified;
  - (3) Projected achievement dates, with measurable indicators or criteria for monitoring progress and assessing achievement of treatment goals; and
  - (4) The name of the employee or community provider responsible for providing treatment required to the resident and the resident's family;
- f. Include and document the involvement from the resident, parent or guardian, public custodial agency, courts, schools, informal social network, residential treatment team members, peer support, or any other individuals important to the resident;
- g. Document the conditions for discharge and estimated discharge date; and
- h. Be reviewed at least every thirty days by the treatment coordinator employee or designated facility clinician. Changes and modifications must be made and documented in writing to ensure appropriateness of the treatment goals.

2. Family treatment. The facility shall plan for how family members are integrated into the treatment process, including postdischarge aftercare services, and how sibling connections are maintained throughout placement. The family section of the resident's treatment plan must include:

- a. Contact information and outreach services with family members, including siblings. The plan must detail how the resident may maintain contact for any known family and appropriate social supports of the resident;

- b. Family-based support during placement;
  - c. Family-based support for at least six months postdischarge;
  - d. Document and provide evidence of the resident's and family's involvement during ongoing planning efforts;
  - e. Document ongoing outreach to and engagement with family members during resident's treatment. The facility shall maintain contact with the resident's custodian and parent or guardian at least weekly. Type of contact may be detailed and includes face-to-face, phone calls, and written communication;
  - f. Date and signature of the resident, employee, custodian, parent or guardian, and others, as applicable; and
  - g. Evidence of facility providing the treatment plan to the resident's custodian and parent or guardian.
3. Visitation plan. The facility shall detail in the resident's treatment plan the agreed upon visitation schedule for the resident from the custodian and parent or guardian. The plan shall identify approved visitors and opportunities for the resident to engage in home visits.
4. Resident acknowledgment. The written treatment plan must include an indication of who must provide treatment coordination, and the residents' signature or the signed statement of the treatment coordinator employee that the treatment plan was explained to the resident and the resident refused to sign the treatment plan.
5. Electronic filing. If a facility engages in electronic data entry and case filing, the facility shall develop a policy to manage this process. The policy must include the electronic medical records process, procedures for internal network security, employee access, and management of facility data, backup systems, and how the facility shall engage in electronic file sharing with the resident's custodian and parent or guardian.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

**75-03-40-36. Discharge plan.**

Each resident must have their discharge plan developed upon admission and reviewed ongoing as part of the treatment plan.

1. Persons involved in discharge planning should include:
- a. Resident;
  - b. Resident's parent or guardian;
  - c. Custodian, if applicable;
  - d. Psychiatrist, if applicable;
  - e. Therapist, if applicable;
  - f. Clinical director;
  - g. Treatment coordinator employee;
  - h. Facility nurse;

- i. Facility educator or community teacher;
- j. Direct care employee;
- k. Foster parents, if applicable;
- l. Juvenile court, if applicable; and
- m. Other individuals important to the resident and family.

2. The discharge plan must address the following:

- a. The date of admission;
- b. The anticipated date of discharge;
- c. Details of the events and circumstances leading to the decision to discharge;
- d. The name and address of the individual or agency to whom the resident must be discharged and the rationale for planning a discharge to that individual or agency;
- e. A summary of services provided during placement;
- f. A summary of goal achievement;
- g. A summary of the resident's continuing needs, including health care, educational or vocational training, psychiatric, medical, psychological, social, behavioral, developmental, and chemical dependency treatment needs;
- h. Appointments scheduled, including individual therapy, psychiatric services, educational services, and other services or supports as needed;
- i. Medication plan, including a seven-day supply of needed medication and a prescription for medication to last through the first outpatient visit with a prescribing provider;
- j. A summary of community-based service needs for the resident and resident's family;
- k. A summary of efforts made by the facility to prepare the resident and the resident's family for discharge; and
- l. The facility's plan for the six months of aftercare services for the resident and the resident's family.

3. The discharge committee shall review and approve each anticipated discharge thirty days prior to the discharge and provide the completed discharge plan to the custodian at least seven days prior to the anticipated discharge. A discharge planning meeting involving the resident, custodian, parent or guardian, facility treatment team, additional family members, community service providers, and foster care provider if the resident is being discharged to another level of foster care, must take place to review and sign the discharge plan to ensure the continuity of services consistent with the resident's treatment needs after discharge.

4. For discharges that were not anticipated at least thirty calendar days ahead of time, the facility shall finalize a discharge plan and provide a written copy to the parent or guardian and custodial agency at least seven days prior to the resident's discharge. A discharge planning meeting to discuss efforts the facility engaged to maintain the placement must take place to review and sign the discharge plan to ensure the continuity of services consistent with the resident's treatment needs after discharge.

5. For unplanned discharges due to the emergency nature of the resident's needs, the facility verbally shall notify the parent or guardian and custodial agency as soon as possible and no longer than twenty-four hours after discharge from the facility. The facility shall send the written discharge plan within seven days after the resident's unplanned emergency discharge.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### 75-03-40-37. Resident and family engagement.

The facility shall create a written policy detailing how the facility embeds foundational concepts of family-driven, resident-guided care into the overall treatment model. The facility's policy shall account for situations in which termination of parental rights has occurred and limitations are set forth in a court order or law. The facility shall document and provide evidence of the resident's and their family's involvement in ongoing treatment planning. Resident and family engagement strategies may include:

1. Ongoing outreach to families during resident's treatment;
2. Engagement of family and resident in treatment;
3. Recognition of resident and family members as co-experts in treatment efforts;
4. Permitting family member onsite visits at any time, encouraging or requiring frequent phone contact, and supporting frequent home visits;
5. Intervention efforts occurring in the home and community whenever possible;
6. Parent involvement, if appropriate, in facility professional development trainings;
7. Resident and family participation in case planning and discharge planning meetings;
8. Resident advocacy and leadership training and opportunities within the facility with access and connections made in the community;
9. Parent advocacy and leadership training opportunities within the facility with access and connections made in the community;
10. Teaching a foundation of negotiation and conflict resolution skills to residents and their families; and
11. Creating and connecting residential intervention with a resident's community through outpatient services and providing a range of supporting services to meet each resident and family where they reside, ranging from traditional office based out-patient to intensive in-home supports, planned and crisis respite care, or skills coaches working in community settings.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### 75-03-40-38. Aftercare.

The facility shall have written policies and procedures regarding how the six-month aftercare requirements must be implemented to best meet the needs of residents and families. Aftercare policy applies to all residents accepted into the facility for treatment. The six-month followup period must begin the day following the resident's discharge from the facility. The facility shall implement the aftercare plan developed as part of the discharge planning process. If a resident discharged from the facility remains in foster care, the facility shall collaborate with the custodial agency to implement the

six-month followup period. If a resident is discharged and no longer in foster care, the facility shall coordinate the ongoing six-month aftercare with the resident and resident's family. The facility may directly provide aftercare services and supports or coordinate with local service providers. The facility shall conduct a department approved postresidential outcomes survey at the conclusion of the six-month required aftercare period.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

**75-03-40-39. Runaway notification.**

1. A facility shall have written policies and procedures for notification if a resident has left the facility without permission or fails to return to the facility after an approved leave. Facility policy and procedures must detail how the determination is made that a resident is missing and must identify the employee designated to promptly complete notifications.
2. Facility notifications include:
  - a. Law enforcement officials and custodian and parent or guardian immediately after the facility confirms the whereabouts of the resident are unknown; and
  - b. The department's interstate compact administrator within forty-eight hours of an out-of-state resident's absence.
3. When the resident is found, the facility shall report the resident's return immediately to the law enforcement officials and the resident's custodian and parent or guardian.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-01

**Law Implemented:** NDCC 50-11-02

**75-03-40-40. Incident and sentinel event reporting.**

The facility shall have written policy outlining the documentation of incidents and sentinel events that occur while the resident is in placement. Policy must include:

1. Description of an incident as an unplanned occurrence that resulted or could have resulted in injury to people or damage to property, specifically involving the general public, residents, or agency employees.
  - a. Incidents involving law enforcement, including in the case of a runaway, criminal activity, behavior resulting in harm to others, or restraint injury. An incident also may involve issues, such as outbreak of a serious communicable disease, harassment, violence, and discrimination.
  - b. Notification must be made to the resident's custodian and parent or guardian immediately or no more than twenty-four hours.
2. Description of a sentinel event as an unexpected occurrence involving death or serious physical or psychological injury not related to the natural course of a resident's illness or underlying condition, including any process variation for which a reoccurrence would carry a significant chance of a serious adverse outcome.
  - a. Sentinel events include serious injury or trauma to a resident, attempted suicide by the resident, death of a resident, or inappropriate sexual contact.



b. Notification must be made to the resident's custodian and parent or guardian, and the department regional office immediately or no more than twelve hours.

3. Documentation of an incident or sentinel event must be completed and placed in the resident's record within twenty-four hours. The report must include:

a. Resident's name, age, and sex;

b. A description of the incident or event;

c. The date, time, and location of the incident or event;

d. The name of each employee or nonemployee involved;

e. Methods used to address the resident's behavior, including duration of each intervention;

f. Detailed description of the technique or approach engaged with the resident at the time of the incident or event;

g. Results achieved from methods used to address resident behavior; and

h. Injuries received by either the resident or an employee in using physically enforced separation or physical hold restraint, how the injuries occurred, and any medical care provided.

4. The facility shall maintain a log of written reports of incidents involving residents.

5. Direct care employees must be given time at the beginning of each shift to be informed of or review incident reports occurring since their last shift.

6. Employees, nonemployees, and residents must be given time to debrief the incident with clinical staff.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-41. Suicide prevention.**

A facility shall develop a suicide prevention plan that addresses several key components, including:

1. Employee and nonemployee training;

2. Intake screening;

3. Ongoing risk assessments;

4. Levels of supervision for resident's;

5. Intervention options;

6. Use of suicide prevention kits with cut down tools;

7. Facility communication, notification, and referral procedures;

8. Reporting and documentation; and

9. Sentinel event debriefing procedures.

**History:** Effective October 1, 2019.



**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

**75-03-40-42. Medical.**

1. The facility shall adopt a comprehensive written plan of preventive, routine, and emergency medical care for residents, including first aid, dental, optical care, and administration of prescription and nonprescription medicine. If a resident is due for a medical examination, the facility shall arrange for a physical examination within seven days of admission and for a dental or optical examination, if needed, within ninety days of admission. The facility shall arrange and provide for necessary remedial and corrective measures for every resident as soon as possible after an examination indicates a need.
2. The facility shall have policies governing the use of psychotropic medications.
3. The facility shall have a plan to separate an ill resident from other residents only if necessary, because of the severity of the illness and it is contagious or infectious.
4. The facility shall have a policy to prevent transmission of infection from all blood or other body fluid exposures, and all employees and nonemployees shall be aware of and follow policy related to universal precautions.
5. The facility shall have a first aid kit on each level of the building housing residents, in buildings where resident activities take place, and in every vehicle used to transport residents. The first aid kit must be placed where it is inaccessible to residents, but accessible to employees and nonemployees. A first aid kit must be inventoried and resupplied after each use.
6. The facility shall have a suicide prevention kit on each level of the building housing residents; including a cut down tool. The kit must be placed where it is inaccessible to residents, but accessible and readily available to employees and nonemployees. A kit must be inventoried and resupplied after each use.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

**75-03-40-43. Medication management.**

1. For purposes of this section:
  - a. "General supervision" means regular coordination, direction, and inspection of the exercise of delegation of medication administration by a physician or nurse of an employee not licensed to administer medications.
  - b. "Medication administration" means proper administration of medication to a resident by an employee designated and trained for the administration of medications.
  - c. "Monitoring of resident self-administration" means distributing the medication to the resident by a designated and trained employee according to physician and medication label instructions and observing and ensuring the proper ingestion, injection, application, or inhalation of the medication by the resident.
2. The facility shall adopt comprehensive written policies and procedures for medication administration and monitoring of resident self-administration. Each employee responsible for administering medication or monitoring of resident self-administration shall receive a copy of the facility policies and procedures for medication administration and monitoring of resident

self-administration and shall be knowledgeable of them. The policies and procedures must include:

a. Medications administration:

- (1) Having written informed consent on file;
- (2) Having information in each resident's health record about any health allergies or health-related restrictions;
- (3) Having on file written authorization from a physician or nurse for each employee permitted to administer medications or to monitoring of resident self-administration;
- (4) Instructions for employees concerning administration of medications and monitoring of resident self-administration of medications, secure storage of medications, and recording medication administration information in the resident's health record;
- (5) Immediate notification to the facility nurse of all medication errors;
- (6) Immediate notification of a physician in the event of a resident's adverse drug reaction; and
- (7) Medications distributed onsite may only occur when an employee authorized by the facility is present;

b. For prescription medications, all of the following apply:

- (1) Require the medication be administered by employees certified to distribute medication to a resident only when:
  - (a) The resident's attending physician or medical consultant provides employees with clear written instructions for administering the medication and authorizes the facility to administer the medication;
  - (b) The administration takes place under the general supervision of a physician or nurse. Employees certified to distribute medication are supervised by the facility nurse; and
  - (c) The label on the medication container gives clear instruction for administration of the medication and, if not clear, the facility shall contact the physician or pharmacy for clarification before administration of the medication; and
- (2) Allowing a medication to be self-administered onsite by a resident only while the resident is under direct supervision of an employee and if self-administration is authorized in writing from the prescribing physician or facility medical consultant;

c. Information to employees, a resident, and the resident's custodian and parent or guardian about any medication prescribed for the resident and when a physician orders any changes to the resident's medication. Information must include expected benefits and potential adverse side effects that may affect the resident's overall treatment. Employees also shall be informed on procedures of what to do if the resident refuses medication;

d. Instructions for employees on what to look for in monitoring physical or mental changes to a resident that may occur from a medication, what to do if physical or mental changes are observed, and documentation needed in the resident's health record;

- e. Arrangement for a second medical consultation when a resident or the resident's custodian and parent or guardian has concerns about any medication received by the resident or the resident's medication plan;
- f. The resident's physician or facility medical consultant review a resident's prescription when there are noted adverse effects from the medication. Documentation showing the date of review and reviewer's name must appear in the resident's health record;
- g. The use of any nonprescription medication is based on an assessment by a physician or nurse and is approved by either a physician or nurse;
- h. Arrangement for administration of prescribed medications to a resident when the resident is away from the facility. A resident may not be given access to medications if there is reason to believe the resident may harm themselves through abuse or overdose;
- i. Medications storage. A facility shall comply with all the following requirements for storage of medications:
  - (1) Medications must be kept in locked cabinets or containers and under proper conditions of sanitation, temperature, light, moisture, and ventilation to prevent deterioration;
  - (2) A facility immediately shall dispose of properly all outdated prescriptions, over-the-counter medication, and all prescription medication no longer in use; and
  - (3) The facility shall maintain a log of the medication properly disposed, which employee disposed of it, and what and how much was disposed;
- j. Medication administration record. A facility shall have in each resident's health record a written medications administration record which lists each prescribed and over-the-counter medication the resident receives. The record must contain the following information:
  - (1) For an over-the-counter medication, the resident's name, type of medicine, reason for use, times and day of administration, and employee authorizing its use; and
  - (2) For a prescription medication, all of the following apply:
    - (a) The name of the resident;
    - (b) The generic or commercial name of the medication;
    - (c) The date the medication was prescribed;
    - (d) The name and telephone number of the prescriber to call in case of a medical emergency;
    - (e) The reason the medication was prescribed;
    - (f) The dosage;
    - (g) The time or times of day for administering the medication;
    - (h) Documentation of all medication administered with the date and time of administration or, if not administered, with the date and time of resident refusal to take it;
    - (i) The method of administration, such as orally or by injection;

(j) The name of the employee who administered or monitored resident self-administration of the medication;

(k) Any adverse effects observed; and

(l) Any medication administration errors and corrective or other action taken; and

k. Psychotropic medications. In this subdivision, "psychotropic medication" means any drug that affects the mind and is used to manage behavior or psychiatric symptoms.

(1) Nonemergency procedures. A facility serving a resident for whom psychotropic medications are prescribed shall ensure all of the following requirements are met:

(a) Arrangements have been made for a physician or medical consultant to complete a medical screening of the resident for the type of psychotropic medication to be prescribed;

(b) The resident, if fourteen years of age or older, and the resident's custodian and parent or guardian have signed written consent forms agreeing to the use of the psychotropic medication; and

(c) The facility has obtained from the prescribing physician or medical consultant a written report within the first forty-five days after the resident has first received a psychotropic medication and at least every sixty days thereafter. The report must state in detail all of the following:

[1] Reasons for the initial use of the medication;

[2] Reasons for continuing, discontinuing, or changing the medication;

[3] Any recommended change in treatment goals or program; and

[4] The method and procedures for administering or monitoring of resident self-administration of a psychotropic medication must have been approved by the prescribing physician or medical consultant.

(2) Emergency procedures. For emergency administration of a psychotropic medication to a resident, a facility shall:

(a) Have authorization from a physician;

(b) Notify the resident's custodian and parent or guardian as soon as possible following emergency administration. The facility shall document the dates, times, and individuals notified in the resident's record; and

(c) Document the physician's reasons for ordering the emergency administration of psychotropic medication.

(3) Revocation of consent or refusal. A resident, custodian, and parent or guardian may at any time revoke consent for nonemergency use of psychotropic medications. When a consent is revoked, the facility shall do all of the following:

(a) Document the reasons for refusal;

(b) Employee who personally witnessed the refusal shall sign a written statement indicating the event and place it in the file;

(c) Notify the resident's physician or medical consultant; and

- (d) Notify the custodian and parent or guardian. Notification must be provided immediately if the resident's refusal threatens the resident's well-being and safety.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

**75-03-40-44. Behavior management intervention.**

1. A facility shall create a trauma informed culture that promotes respect, healing, and positive behaviors and which minimizes the use of restrictive behavior management interventions to the extent possible.
2. The facility shall provide the resident, custodian, and parents or guardians a list of facility expectations and behavior management intervention guidelines.
3. A facility shall adopt and implement written policies and procedures for behavior management consistent with the following:
  - a. Compliance with the standards of the facility's accrediting body.
  - b. Behavior management interventions must be constructive or educational in nature.
  - c. Only employees of the facility may prescribe, administer, or supervise the behavior management interventions of the resident.
  - d. A resident may not be subject to:
    - (1) Physical abuse;
    - (2) Excessive physical exercise or other activities causing physical discomfort;
    - (3) Unduly strenuous physical work;
    - (4) Verbal abuse, ridicule, or humiliation;
    - (5) Penalizing a group for an identified group member's misbehavior;
    - (6) Any aversive measure that is painful, discomforting, dangerous, or potentially injurious; or
    - (7) Denial of any of the following items:
      - (a) Shelter;
      - (b) Emotional support;
      - (c) Sleep;
      - (d) A place to sleep with a pillow and bedding;
      - (e) Meals or menu items;
      - (f) Clean clothes;
      - (g) Personal or telephone visits with the resident's custodian, parent or guardian, or advocate;

(h) Time necessary for personal hygiene;

(i) Minimum exercise;

(j) Mail;

(k) Access to toilet and water facilities, as needed;

(l) Attendance at a religious service or religious counseling;

(m) Clean and sanitary living conditions;

(n) Medication;

(o) Program services or treatment; or

(p) Entry to the facility.

4. For the purposes of this section, "time-out" means a behavior management intervention technique that is part of an approved program that involves the voluntary option of a resident to move to an unlocked designated area for a period of time to regain self-control.

5. Application of time-out by a facility must be as follows:

a. A resident in time-out must never be physically prevented from leaving the time-out area.

b. Time-out may take place away from the area of activity or from other residents, such as in the resident's room, or in the area of activity or other residents.

c. An employee continuously shall observe the resident while the resident is in time-out and provide calming assistance as prescribed in the resident's treatment plan.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-45. Emergency safety interventions.**

The facility shall provide and administer emergency safety interventions as follows:

1. For purposes of this section:

a. "Drug used as a restraint" means any drug that:

(1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;

(2) Has the temporary effect of restricting the resident's freedom of movement; and

(3) Is not a standard treatment for the resident's medical or psychiatric condition.

b. "Emergency safety intervention" means the use of restraint or seclusion as an immediate response to an emergency safety situation involving unanticipated resident behavior that places the resident or others at threat of serious violence or serious injury if no intervention occurs.

c. "Emergency safety situation" means a situation where immediate risk of harm is present due to unanticipated resident behavior that places the resident or others at threat of

serious violence or serious injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

d. "Personal restraint" means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another, or a physical escort which means a temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a resident who is acting out to walk to a safe location.

e. "Tier 1 mental health professional" has the same meaning as the term defined in subsection 8 of North Dakota Century Code section 25-01-01.

## 2. Education and training related to emergency safety interventions:

a. Individuals who are qualified by education, training, and experience shall provide employee education and training.

b. Employees must be trained and demonstrate competency before participating in an emergency safety intervention.

c. The facility shall document in the employee personnel records that the training and demonstration of competency were successfully completed.

d. All training programs and materials used by the facility must be available for review by the accreditation body and the state agency.

e. The facility shall require employees to have ongoing education, training, and demonstrated knowledge and competency of all of the following, no less than semiannually:

(1) Techniques to identify employee and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations;

(3) The safe use of restraint and seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion; and

(4) Training exercises in which employees successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

## 3. Emergency safety intervention:

a. Facilities shall have a policy for the safe use of emergency safety interventions;

b. Restraint and seclusion may be used only when a resident poses an immediate threat of serious violence or serious injury to self or others and must be discontinued when the immediate threat is gone;

c. Employees shall document all interventions attempted to de-escalate a resident before the use of seclusion or restraint are implemented;



d. When restraint is deemed appropriate, personal restraint is allowed. Mechanical restraints, prone restraints, and drugs used as a restraint are prohibited;

e. Employee training requirements must include procedures:

(1) For when seclusion or restraint may and may not be used;

(2) That safeguard the rights and dignity of the resident;

(3) For obtaining informed consent, including the right of the custodian and parent or guardian of the resident to be notified of any restraint or seclusion use or any change in policy or procedure regarding use;

(4) Regarding documentation requirements of each episode of seclusion or restraint and the use of such data in quality improvement activities; and

(5) Regarding the debriefing of the resident and employees immediately after incidents of seclusion or restraint; and

f. Quality management activities must examine the following:

(1) Available data on the use of these practices and their outcomes, including the frequency of the use of restraint and seclusion, settings, authorized employees, and programs;

(2) The accuracy and consistency with which restraint and seclusion data are being collected, as well as the extent to which these data are being used to plan behavioral interventions and employee training;

(3) Whether policies and procedures for using these practices are being implemented with fidelity;

(4) Whether procedures continue to protect residents; and

(5) Whether existing policies for restraint and seclusion remain properly aligned with applicable state and federal laws.

#### 4. Restraint:

a. Personal restraint is the only form of restraint allowed.

b. If an emergency safety situation occurs and a personal restraint is determined necessary, the following actions are prohibited:

(1) Any maneuver or techniques that do not give adequate attention and care to protection of the resident's head;

(2) Any maneuver that places pressure or weight on the resident's chest, lungs, sternum, diaphragm, back, or abdomen causing chest compression;

(3) Any maneuver that places pressure, weight, or leverage on the neck or throat, on any artery, or on the back of the resident's head or neck, or that otherwise obstructs or restricts the circulation of blood or obstructs an airway, such as straddling or sitting on the resident's torso;

(4) Any type of choke hold;



- (5) Any technique that uses pain inducement to obtain compliance or control, including punching, hitting, hyperextension of joints, or extended use of pressure points for pain compliance; and
- (6) Any technique that involves pushing on or into a resident's mouth, nose, or eyes, or covering the resident's face or body with anything, including soft objects, such as pillows, washcloths, blankets, and bedding.

5. Seclusion:

a. A resident may be maintained in seclusion only by one of the following means:

- (1) A room that does not use a key lock, pad lock, or other lock of similar design and remains unlocked;
- (2) A room equipped with a lock that only operates with an employee present such as a push-button lock that only remains locked while it is being pushed; or
- (3) A room or area where an employee is positioned to prevent the resident from leaving.

b. A resident placed in seclusion must be continuously observed by an employee.

c. A room used for seclusion must:

- (1) Hold only one resident at a time;
- (2) Have adequate ventilation;
- (3) If there is a door, a shatter-proof observation window on or adjacent to the door, which allows for observation of all parts of the room and allows for the resident to see out;
- (4) Be located within hearing or call to a living area or other area of activity;
- (5) Allow for auditory contact with the resident at all times;
- (6) Have at least sixty-four square feet [5.95 square meters] of floor space with a ceiling height of not less than eight feet [2.44 meters] and a width of at least eight feet [2.44 meters];
- (7) Be an architectural or permanent part of the building structure and may not include a box or other compartment that represents a stand-alone unit within the facility; and
- (8) Be free of any objects and materials that could represent a hazard to the resident or others.

6. Orders for the use of restraint or seclusion:

a. Orders for restraint or seclusion must be ordered by a tier 1 mental health professional and the ordering tier 1 mental health professional must be trained in the use of emergency safety interventions.

b. The order must indicate the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with the clinical director.

c. If the order for restraint or seclusion is verbal, the verbal order must be received by a nurse or clinical director, while the emergency safety intervention is being initiated by an

employee or immediately after the emergency safety situation ends. The tier 1 mental health professional must verify the verbal order in a signed written form in the resident's record and be available to the resident's treatment team for consultation in person or through electronic means throughout the period of the emergency safety intervention.

d. Each order for restraint or seclusion:

(1) Must be limited to no longer than the duration of the emergency safety situation;

(2) May not exceed four hours for residents ages eighteen to twenty-one; two hours for residents ages nine to seventeen; or one hour for residents under age nine; and

(3) Must be signed by the ordering tier 1 mental health professional no later than twelve hours from initiation of a verbal order.

e. Within one hour of the initiation of the emergency safety intervention, a face-to-face assessment of the physical and psychological well-being of the resident must be completed, documenting:

(1) The resident's physical and psychological status;

(2) The resident's behavior;

(3) The appropriateness of the intervention measures; and

(4) Any complications resulting from the intervention.

f. Each order for restraint or seclusion must include:

(1) The name of the ordering tier 1 mental health professional;

(2) The date and time the order was obtained; and

(3) The emergency safety intervention ordered, including the length of time authorized.

g. An employee shall document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

(1) Each order for restraint or seclusion as required in subdivision f;

(2) The time the emergency safety intervention began and ended;

(3) The time and results of the one-hour assessment required in subdivision e;

(4) The emergency safety situation that required the restraint or seclusion; and

(5) The name of each employee involved in the emergency safety intervention.

h. The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

i. If a tier 1 mental health professional orders the use of restraint or seclusion, that person shall:

- (1) Consult with the resident's treatment team physician as soon as possible and inform the resident's treatment team physician of the emergency safety situation that required the restraint or seclusion; and
- (2) Document in the resident's record the date and time the resident's treatment team physician was consulted.

7. Monitoring of the resident in and immediately after restraint or seclusion:

- a. An on-call clinical team member trained in the use of emergency safety interventions shall be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint or seclusion throughout the duration of the emergency safety intervention.
- b. If the emergency safety situation continues beyond the time limit of the order for the use of restraint or seclusion, a nurse or other on-call clinical team member, immediately shall contact the ordering tier 1 mental health professional, to receive further instructions.
- c. Upon completion of the emergency safety intervention, the resident's well-being must be evaluated immediately after the restraint or seclusion is removed or has ended.

8. Notification of custodian and parent or guardian:

- a. The facility shall notify the custodian and parent or guardian of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.
- b. The facility shall document in the resident's record that the custodian and parent or guardian has been notified of the emergency safety intervention, including the date and time of notification and the name of the employee providing the notification.

9. Postintervention debriefings:

- a. Within twenty-four hours after the use of restraint or seclusion, employees involved in an emergency safety intervention and the resident shall have a face-to-face discussion. This discussion must include all employees involved in the intervention except when the presence of a particular employee may jeopardize the well-being of the resident. Other employees and the resident's custodian and parent or guardian may participate in the discussion when it is deemed appropriate by the facility. The facility shall conduct such discussion in a language understood by the resident's custodian and parent or guardian. The discussion must provide all parties the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the facility, the resident, or others who could prevent the future use of restraint or seclusion.
- b. Within twenty-four hours after the use of restraint or seclusion, all employees involved in the emergency safety intervention, and appropriate supervisory and administrative leadership, shall conduct a debriefing session that includes, at a minimum, a review and discussion of:
  - (1) The emergency safety situation that required the emergency safety intervention, including a discussion of the precipitating factors that led up to the emergency safety intervention;
  - (2) Alternative techniques that might have prevented the use of the restraint or seclusion;

(3) The procedures, if any, employees are to implement to prevent any recurrence of the use of restraint or seclusion; and

(4) The outcome of the emergency safety intervention, including any injuries that may have resulted from the use of restraint or seclusion.

c. An employee shall document in the resident's record that both debriefing sessions took place and shall include in that documentation the names of employees who were present for the debriefing, names of employees excused from the debriefing, and any changes to the resident's treatment plan that resulted from the debriefings.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-46. Use of special care unit.**

1. For purposes of this section, "special care unit" means a separate secure area of the facility designated as a protective environment in which treatment and services are provided to residents. The special care unit is secured by means of a key lock that prevents residents from leaving at will. A special care unit is not seclusion, but rather a fully operational separate space located on the facility's grounds. A facility building locked for purposes of external security is not the special care unit, provided that residents may exit at will.

2. Conditions for use. A resident may not be placed in a special care unit unless the facility has first obtained department approval to operate the special care unit and the special care unit meets the requirements of this section.

3. If an emergency safety situation arises in the special care unit requiring the use of the emergency safety interventions of restraint or seclusion for a resident placed within the special care unit, then section 75-03-41-45 applies.

4. A facility's use of the special care unit must be part of a behavior management program and all of the following conditions must be met:

a. The resident has exhibited chronic or recent severely aggressive or destructive behaviors that have been determined to place the resident or others at serious threat of violence or injury to self or others and the lack of the special care unit prevents the clinical team from being able to treat the resident.

b. A tier 1 mental health professional knowledgeable about contemporary use of the special care unit treatment intervention gives written approval included in the resident's treatment record for its use.

c. The goals, objectives, and approaches in the resident's treatment plan support the use of the special care unit, with goals and objectives directed at reducing or eliminating the need for use of the special care unit.

d. The custodian, or if there is no court appointed custodian, the parent or guardian of the resident gives informed consent in writing to the use of a special care unit or the intervention is ordered by a court or other lawful authority.

e. The resident has no known medical or mental health condition that would place the resident at risk or harm from being placed in a special care unit as evidenced by a statement from a tier 1 mental health professional.

f. The clinical team conducts at least a weekly assessment for the continued need.

5. Appropriately trained employees shall supervise the use of a special care unit directly, with evidence of training in their employee file training record.
6. A facility with a special care unit shall have written policies and procedures that include the following:
  - a. A resident may be placed in the special care unit only if there is a written informed consent document signed by the resident's custodian, or if there is no court appointed custodian the parent or guardian or by an order of a court or other lawful authority. A copy of the informed consent document, court order, or document from another lawful authority shall be filed in the resident's treatment record.
  - b. Custodian's, or if there is no court appointed custodian, the parent or guardian's written informed consent for placement of a resident in the special care unit must be effective for no more than forty-five days from the date of the informed consent and may be withdrawn sooner unless otherwise specified in a court order or by another lawful authority.
  - c. Custodian's, or if there is no court appointed custodian, the parent or guardian's written informed consent for continued use of the special care unit may be renewed for thirty-day periods except as otherwise specified in a court order or by another lawful authority. Each renewal of informed consent must be through a separate written informed consent document.
  - d. Except as otherwise specified in a court order or by another lawful authority, the custodian, or if there is no court appointed custodian, the parent or guardian may withdraw their written informed consent to the resident being placed in the special care unit at any time, orally or in writing. The resident must be transferred out of the special care unit promptly following withdrawal of the informed consent.
  - e. All employees supervising residents in the special care unit shall have the means to unlock the unit immediately.
  - f. The special care unit must be furnished in a manner that minimizes the use of items by a resident in a harmful way.
  - g. A facility shall provide in each special care unit one resident care worker with no assigned responsibilities other than direct supervision of the residents. During hours when residents are awake, there must be one resident care worker for every two residents. During sleeping hours, there must be one resident care worker for every four residents. There must be a minimum of two workers always present in the special care unit. Employees shall be present in the special care unit with residents and shall have the means to immediately summon additional clinical support as needed.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-47. Buildings, grounds, and equipment.**

1. A facility shall comply with all state, county, and local building and zoning codes and ordinances as well as all applicable state, county, and local safety, sanitation laws, codes, and ordinances.
2. A facility must be inspected annually by the local fire department or the state fire marshal's office. A facility shall correct any deficiencies found during these inspections. The facility shall keep a written report of the annual inspection and provide a copy to the department, including

evidence of correction of noted deficiencies. All chimneys, flues, and vent attachments to combustion-type devices must be structurally sound, appropriate to the unit or units attached to them, and cleaned and maintained as necessary to provide safe operation. The heating system of each facility, including chimneys and flues, must be inspected at least once each year by a qualified individual.

3. There must be at least one 2A 10BC fire extinguisher on each floor and in or immediately adjacent to the kitchen, incinerator, and combustion-type heating units. Additional fire extinguishers must be provided so it is never necessary to travel more than seventy-five feet [22.86 meters] to an extinguisher. Fire extinguishers must be mounted on a wall or a post where they are clearly visible and at a readily accessible height. All required fire extinguishers must be checked once a year and serviced as needed. Each fire extinguisher must have a tag or label securely attached indicating the month and year the maintenance check was performed last and the individual who performed the service.
4. The facility shall provide the following smoke detectors:
  - a. One unit for each bedroom hallway;
  - b. One unit at the top of each interior stairway; and
  - c. One unit for each room with a furnace or other heat source.
5. Battery-operated smoke detectors must signal when the battery is exhausted or missing and be tested at least once a month.
6. Carbon monoxide detectors must be operational as recommended by the local fire department or state fire marshal.
7. The facility must be equipped with furnishings suitable to the needs of the residents. Recreational space and equipment must be safe, functional, and available for all residents.
8. The facility shall have one centrally located living room for the informal use of residents.
9. The facility shall have a dining room area large enough to accommodate the number of residents served.
10. A facility shall provide space and privacy for individual interviewing and counseling sessions. This space must be separate and apart from rooms used for ongoing program activities.
11. A facility shall have bedroom accommodations for the residents as follows:
  - a. The facility shall have at least one bedroom for each three residents;
  - b. The facility may not permit nonambulatory residents to sleep above or below the ground floor;
  - c. There may be no more than one resident per bed, and triple bunks are prohibited;
  - d. All bedrooms must have at least one window that opens to the outside;
  - e. A sleeping room may not be in an unfinished attic, hallway, or other room not normally used for sleeping purposes;
  - f. A basement that has over half its outside walls below grade and no door opening directly to the outside may not be used for bedrooms, unless the bedroom space has egress windows;



- g. Furnishings must be safe, attractive, easy to maintain, and selected for suitability to the age and development of the residents; and
- h. A facility shall have sufficient individual storage areas to accommodate resident's clothing and other personal belongings.
- 12. A facility shall have one complete bathroom to include a toilet, washbasin, and a tub or shower for each six residents and:
  - a. All bathroom facilities must be indoors, equipped with hot and cold running water, and kept clean;
  - b. When bathroom units contain more than one toilet, tub, or shower, each must be in a separate compartment; and
  - c. The facility shall provide bathrooms with nonslip surfaces in showers or tubs.
- 13. Facilities shall ensure kitchen equipment and area meet the standards prescribed by the state department of health for food and beverage establishments. Compliance with these standards must be documented annually and inspection documentation must be provided to the department. A facility shall ensure:
  - a. Food storage space is clean, and containers are covered and stored off the floor;
  - b. Dishes, cups, and drinking glasses used by the residents are free of chips, cracks, and other defects, and are sanitized after every use by a washing process, sanitization solution, and air-drying or commercial dishwasher; and
  - c. Kitchen floors are reasonably impervious to water, slip-resistant, and maintained in a clean and dry condition.
- 14. Laundry facilities must be located in an area separate from areas occupied by residents. Space for sorting, drying, and ironing must be made available to residents who are capable of handling personal laundry.
- 15. The water supply of a facility must be from an approved municipal system where available. Where a municipal system is not available, a water sample must pass the approved drinking water standard bacteriological water analysis testing. The facility shall obtain results from an environmental protection agency approved laboratory for testing through licensing with the department of environmental quality.
- 16. Alcohol, tobacco, and vaping is prohibited in the facility.
- 17. All toxic cleaning supplies, aerosols, chemical, agricultural and ground maintenance chemicals, pesticides, and other poisons must be stored in a locked cabinet.
- 18. All shampoos, body wash, hand sanitizers, and perfumes, must be distributed in a limited quantity to a resident. These items must be stored in a locked cabinet when not distributed to residents.
- 19. Firearms are prohibited in program or living areas of a facility premises. Firearms kept at any other location on the facility premises must be stored in a locked and secure area.
- 20. A facility shall have a quiet area to be used for studying and furnished for that purpose.
- 21. All rooms in a facility must have adequate lights, heat, and ventilation. All bathrooms must have a window which opens to the outside or exhaust ventilation.

22. Buildings and grounds of a facility must be maintained in a clean, comfortable, sanitary, and safe condition.

a. The facility may not be located within three hundred feet [91.44 meters] of an aboveground storage tank containing flammable liquids used in connection with a bulk storage or other similar hazards;

b. The grounds must be attractive, well-kept, and spacious enough to accommodate recreational areas that take into consideration the age and interest levels of residents;

c. Rooms, exterior walls, exterior doors, skylights, and windows must be weathertight and watertight;

d. Stairways, porches, and elevated walks and ramps must have structurally sound and safe handrails;

e. Buildings must be free of unabated asbestos; and

f. Lead paint may not be used within a building or on the exterior, grounds, or recreational equipment.

23. Any nonhousing buildings located on the facility property must be locked when not in use by employees, nonemployees, or residents. Residents must be supervised by an employee when entering a nonhousing building.

24. All pet inoculations must comply with the local and state requirements.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-48. Food and nutrition.**

1. The facility shall appoint an employee to be responsible for complying with requirements for healthy and safe food and nutrition practices.

2. All food service personnel shall have in-service training annually. Training topics must relate to proper food handling procedures, maintenance of sanitary conditions, and food service arrangements. Documentation of annual training must be kept in the employee's file.

3. Food must be in wholesome condition, free from spoilage, filth, or contamination and must be safe for human consumption. Food in damaged containers or with expired freshness dating is not considered safe for human consumption.

4. The facility shall ensure the nutritional requirements of the residents are met. The facility shall serve nutritionally balanced meals each day. Medically required special diets must be prepared for residents as needed.

5. Except for garden produce, all homegrown food, poultry, meat, eggs, and milk must be from an approved source as determined by the state or local health authorities. The facility shall document the approval of state or local health authorities.

6. No home-canned foods may be served.

7. Frozen homegrown food products may be served if maintained in compliance with standards prescribed by the state department of health for food and beverage establishments.



8. The facility shall provide refrigeration for perishable food and shall maintain perishable food in accordance with standards prescribed by the state department of health for food and beverage establishments.
9. Employees, nonemployees, and residents helping to prepare food shall wash their hands before handling food, and as often as necessary to keep them clean, and shall use effective hair restraints to prevent contamination of food and food contact surfaces.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-49. Resident accommodations.**

1. The facility shall arrange for residents to have a personal supply of clean, well-fitting clothing and shoes for both indoor and outdoor wear and appropriate for the season.
2. The facility shall make room assignments to best meet the needs and vulnerabilities of residents. The facility shall assess room assignments on an ongoing basis to minimize potential risk to residents.
3. The facility shall provide residents personal hygiene and toiletries, including washcloths and towels which must be changed when soiled, and no less often than weekly.
4. The facility shall provide residents a bed with a clean mattress and bedding. The facility shall provide additional blankets to each resident as temperatures make necessary. Sheets and bedding must be changed when soiled, and no less often than weekly.
5. A facility that assigns jobs and household responsibilities for residents shall do so in a manner that does not conflict with the education and treatment schedule or physical health of the residents or preclude the opportunity for socialization activities.
6. Participation in recreational and social activities must be on the basis of the individualized needs and treatment goals of each resident.
7. The facility shall advise all residents and the resident's custodian and parent or guardian, in writing, of the day-to-day rules of the facility. The facility shall adopt day-to-day rules that create the least restrictive environment, consistent with the treatment needs of residents. The rules must include:
  - a. A general description of acceptable and unacceptable conduct;
  - b. A resident's individual freedoms when involved in recreational or school activities away from the facility; and
  - c. Consequences for a resident who violates a facility rule.
8. The facility shall advise residents and the resident's custodian and parent or guardian, in writing, of the process used by employees to complete a search of residents or their belongings when returning to the facility from offsite outings, events, school, or home visits. The facility shall inform residents of the reason searches may be conducted, the protocol for conducting searches, and any disciplinary action a facility may take if contraband items are identified during a search.
9. A facility shall ensure privacy is made available when a custodian, parent, guardian, or family member arrives onsite to visit a resident. The facility shall record any reason for restricting

communications or visits between a resident and the resident's custodian, parent, guardian or family members in the resident's file.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

### **75-03-40-50. Transportation.**

This section applies to the transportation of residents in a facility-owned or leased vehicle, driven by an employee or nonemployee. A facility shall develop a comprehensive transportation policy addressing the following:

1. Driver information. A facility shall maintain a list of approved employee and nonemployee drivers. The list must indicate the name of each driver, type of license held, and the date of expiration of the license. The list must be on file at the facility.

2. Driver qualifications.

a. The driver must hold a current valid operator's license for the type of vehicle being driven, be at least twenty-one years of age, and have at least one year of experience as a licensed driver;

b. Before a driver may transport residents, the facility shall obtain a copy of their driver's license. A copy of a valid driver's license must remain in the employee or nonemployee file; and

c. Before a driver may transport residents, the facility initially shall check the driver's driving record for any driving safety violations. A copy of the employee's or nonemployee's driving record must be obtained annually and placed in the employee's or nonemployee's file. The facility shall develop policy to address safety-related driving violations and the ability to transport residents.

3. Vehicle capacity and supervision.

a. A facility shall meet employee-to-resident ratios; and

b. A facility shall determine if additional supervision is required to minimize risk while transporting, based on the resident's needs.

4. Vehicle operation. Any vehicle used by a facility for the transportation of residents must:

a. Be maintained and inspected on a monthly basis, with records of inspections maintained at the facility;

b. Be registered and licensed in accordance with North Dakota law and carry vehicle liability insurance;

c. Have a first aid kit stored inside the vehicle;

d. Have a log to track date and time of the transport, who was driving, and the residents in the vehicle. The log book also must list emergency contact information for community first responders and facility administration to notify in case of an accident;

e. Have operating seat belts for the use of all occupants on each transport;

f. Prohibit smoking, tobacco use, and vaping; and

g. Prohibit the use of a cell phone while operating the vehicle.

5. Accident report. A facility shall implement a policy for employees and nonemployees to follow when operating a facility vehicle impacted by a motor vehicle accident. In addition, the facility shall keep on file a copy of the official police report of any accident involving a facility vehicle transporting residents.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-51. Water safety.**

1. For purposes of this section, "aquatic activity" means an activity in or on a body of water, either natural or manmade, including rivers, lakes, streams, swimming pools, or water slides. Water activities are prohibited in waters the facility knows contain health-threatening pollutants.
2. The facility shall determine the swimming ability of each resident prior to engaging in an aquatic activity. The facility may not permit any resident to participate in an aquatic activity requiring higher skills than the resident's swimming classification, except during formal instruction.
3. The facility may not permit residents to engage in an aquatic activity without adult supervision at all times and without regard to sufficient weather and resident abilities.
4. The facility shall adopt and enforce a method to account for each resident's whereabouts during aquatic activities, such as a buddy system.
5. The facility shall require all activity participants wear personal flotation devices during all boating activities, including water skiing, canoeing, tubing, and rafting.
6. Prior to any travel in any watercraft, the facility shall provide safety instructions.
7. The requirements of this section apply to activities wherever the activities take place. If the location where aquatic activity takes place does not have lifesaving equipment available, the facility is required to provide facility-owned lifesaving equipment. The facility shall provide and maintain lifesaving equipment in good repair and shall maintain documentation of equipment maintenance. All lifesaving equipment utilized by the facility must be listed in policy and immediately accessible in case of an emergency.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

#### **75-03-40-52. Variance.**

Upon written application and good cause shown to the satisfaction of the department, the department may grant a variance regarding a specific provision of this chapter upon such terms as the department may prescribe, except no variance may permit or authorize a danger to the health or safety of any resident cared for by the facility and no variance may be granted except at the discretion of the department. A facility shall submit a written request to the department justifying the variance. A refusal to grant a variance is not subject to appeal.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-11-03

**Law Implemented:** NDCC 50-11-02

## **CHAPTER 75-03-41**

### **SUPERVISED INDEPENDENT LIVING**

#### Section

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#### **75-03-41-01. Definitions.**

As used in this chapter:

1. "Agency" means the public or private entity licensed by the department to provide supervised independent living programming to eligible clients.
2. "Client" means an eligible individual between the ages of eighteen and twenty-four years.
3. "Continued foster care services" is a voluntary foster care program to allow a foster child to remain in or return to foster care between the ages of eighteen and twenty-one while in the placement and care of a public agency, but not in public custody.
4. "Employee" means an individual compensated by the agency to work in a part-time, full-time, intermittent, or seasonal capacity for the agency. This definition is not inclusive to contracted service providers who come onsite to conduct trainings, treatment groups, individual therapy, or other program services.
5. "Licensee" means an agency either licensed by the department or approved by the department if the agency is located within a tribal jurisdiction.

6. "Nonemployee" means an individual who is not compensated by the agency, such as a volunteer or student intern providing a specific service under the supervision of an employee.
7. "Placement and care agency" means a public agency granted legal placement and care authority.
8. "Supervised independent living program" means a program offered by an agency providing services and supports to eligible clients transitioning to independence.
9. "Supervised independent living setting" means a specific setting certified in accordance with the standards set forth by the agency to operate a supervised independent living program.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-00.1

### **75-03-41-02. Application - Effect of license.**

1. Application for a supervised independent living program license must be made on an application provided by the department.
2. At the initial application, the applicant shall submit a written purpose and policy statement for the general operation and management of the supervised independent living program. The information submitted to the department for consideration must include:
  - a. The purpose of the supervised independent living program;
  - b. The geographic area the applicant expects to serve;
  - c. The ages of eligible clients to be served;
  - d. Written placement policy and agreement forms; and
  - e. Written statement of the fees associated with the service.
3. Upon receipt of the application for licensure or renewal of license, the department shall conduct a licensing study or a license review to determine if the applicant meets all applicable requirements for licensure.
4. After completion of a licensing study or license review, the department shall issue a license to any applicant that meets all requirements for licensure to provide a supervised independent living program.
5. Each agency shall carry general comprehensive liability insurance.
6. The department shall renew the license on the expiration date of the previous license if:
  - a. The agency makes written application for renewal prior to the expiration date of its current license; and
  - b. The agency continues to meet all requirements for licensure at the time of the licensing study or license review.
7. If the department determines an application, renewal of license, or accompanying information is incomplete or erroneous, the department shall notify the applicant of the specific deficiencies or errors, and the applicant shall submit the required or corrected information. The

department may not issue or renew a license until it receives all required or corrected information.

8. A supervised independent living program license is in force and effect for the period stated thereon, not to exceed two years, is nontransferable, and is valid only to the agency providing the program oversight for the number of clients indicated on the license.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11

#### **75-03-41-03. Denial or revocation.**

1. After written notice to the applicant or licensee, the department may deny, suspend, or revoke a supervised independent living program application or license upon finding the applicant or agency:

- a. Is not in compliance with all licensure requirements; or

- b. Has made a material misrepresentation to the department regarding its operations.

2. An applicant or agency whose application or license has been denied or revoked, may appeal to the department under the provisions of North Dakota Century Code sections 50-11-08 and 50-11-09. The agency may continue the operation of the program pending the final administrative determination or until the license expires, whichever occurs first; provided, this subsection does not limit the actions the department may take pursuant to North Dakota Century Code chapter 50-11.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-07, 50-11-08, 50-11-09

#### **75-03-41-04. Correction orders.**

1. The department may require immediate correction of a violation that threatens the life or safety of a client in the licensed supervised independent living program.

2. All time periods under this section commence on the third day after the department mails notice of the correction order to the agency.

3. Upon written request by the agency and upon showing need for an extension created by circumstances beyond the control of the agency and that the agency has diligently pursued correction of the violation, the department may grant extensions of time to correct violations.

4. The department may inform the public of an agency correction order status.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-04.2

#### **75-03-41-05. Agency program closure.**

The agency shall have a policy to ensure proper and efficient procedure in the event a supervised independent living program closes. Prior to closing, the agency program administrator shall provide at least a sixty-day written notice to the department:

1. Detailing a plan for closure, including:
  - a. Date of closure;
  - b. Plan to notify clients and placement and care agency, when applicable;
  - c. Identification of a North Dakota depository to maintain the agency case, fiscal, and employee and nonemployee records; and
  - d. Retention of all fiscal records for a period of seven years following account settlement.
2. Written notification must be given to each client and placement and care agency at least forty-five days prior to program closure.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-06. Governance and administration.**

1. The agency shall have a governing body that is responsible for the policies, activities, practice, and overall operations of the agency. The governing body shall:
  - a. Be composed of at least five members. A list of the names and contact information of members of the governing body must be maintained and submitted to the department annually. Each board member shall annually disclose conflicts of interest. Members of the board may not be family or have conflicts of interest with agency administration or employees with budget or accounting duties;
  - b. Meet at least every six months;
  - c. Maintain records of the governing body's meetings;
  - d. Develop and review policies for member selection and rotation;
  - e. Ensure each board member understands the agency operation and program goals;
  - f. Ensure the agency is funded, housed, staffed, and equipped in a manner required for the provision of services;
  - g. Approve the agency's annual budget of anticipated income and expenditures necessary to provide services described in the program's statement of purpose;
  - h. Provide financial statements and audits to the department for reimbursement purposes, upon request;
  - i. Ensure the agency has an active strategic plan with a schedule to review annually;
  - j. Adopt a written statement of the purpose and philosophy of the agency; and



k. Adopt written policies for the agency regarding administration, personnel, and program services. Personnel policies for the recruitment and retention of employees necessary to operate the agency must indicate expectations of employees and nonemployees, detail job descriptions for each position, and ensure a process to review policies and procedures with employee participation at least every five years.

2. All statements and policies required by this chapter must be in writing to demonstrate the intent of the standards are integrated into agency practice. The agency policy must be up to date.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-07. Financial structure.**

1. For purposes of initial licensure, the applicant shall demonstrate the applicant has sufficient income to operate the applicant's program of services and, upon relicensure, the agency shall demonstrate ongoing financial stability.

2. The agency shall prepare an annual budget based on the assessment of agency program priorities and appraisal of anticipated funding, including reimbursement for services. The agency shall submit a copy of its budget to the department with a cost breakdown of budget items utilized to determine fees for services.

3. The agency shall maintain liability insurance as protection for its governing body, staff, clients, funds, and property. The agency shall review the liability insurance annually to assure adequate agency coverage.

4. The supervised independent living program ratesetting must be negotiated with the department for clients who meet the continued foster care services criteria. Ratesetting may include the review of program costs and client outcomes.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-08. Disaster plan.**

The agency shall have a written disaster plan to accommodate emergencies. The disaster plan must allow the department and placement and care agency to identify, locate, and ensure continuity of services to clients who are displaced or adversely affected by a disaster. The agency shall ensure the disaster plan specifies:

1. Agency responsibilities and contact information;

2. Primary and alternate plans for evacuation specific to the setting, including transportation, relocation, and evacuation of injured individuals;

3. Supervision and followup with clients after evacuation or relocation;

4. Where clients and if applicable, employees or nonemployees, would go in an evacuation, including one location in the nearby area and one location out of the area;



5. The process the agency must use to inform the clients, department, and placement and care agencies of clients who are displaced or adversely affected by a disaster;
6. Employee training on the disaster plan that details the procedures for meeting disaster emergencies. The review of the disaster plan must occur with employees on an annual basis to ensure it is current, accurate, and employees understand their role; and
7. Client training on the disaster plan ensuring awareness of all emergency and evacuation procedures upon acceptance to the program and approved supervised independent living setting. These procedures must be reviewed at time of placement and every six months thereafter.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

### **75-03-41-09. Confidentiality.**

1. Except as otherwise provided in this section, agency records concerning clients that have received, are receiving, or seek to receive supervised independent living programming must be safeguarded. The agency shall ensure the safety of client records against loss, theft, defacement, tampering, or use by unauthorized persons. Any documents containing identifying information regarding the client must be locked when unattended by staff.
2. The agency may not make public or otherwise disclose by electronic, print, or other media for fundraising, publicity, or illustrative purposes, any image or identifying information concerning any client or member of the client's family without first securing the written consent of the appropriate parties.
3. Client consent is not required to release confidential information if situations where the safety of the client or other individuals are at risk, child abuse or neglect is suspected, or other compelling professional reasons exist.
4. The agency shall have policy in place to ensure all clients served have a responsibility for keeping confidentiality of other clients in the program. This includes not confirming or denying another client's participation in the program to outside persons or agencies via telephone, face-to-face, social media, electronic communications, or written requests.
5. The agency shall have written policies regarding retention of client records and supervised independent living program personnel files.
6. The agency shall disclose its records to the department as requested.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-05

### **75-03-41-10. Quality assurance.**

A supervised independent living program shall have a performance and quality improvement plan that advances efficient, effective service delivery, management practices, and the achievement of goals and outcomes.

1. An agency shall have a written quality assurance plan that defines:

- a. Approach to quality improvement;
  - b. Employee roles and responsibility for implementing and coordinating quality assurance;
  - c. Data outcomes tracked and collection processes; and
  - d. Processes for reporting findings and monitoring results.
2. An agency quality assurance plan must include agency performance and client outcomes which identify measures of the following client outcomes:
- a. Employment;
  - b. Education;
  - c. Permanent connections;
  - d. Health insurance coverage;
  - e. Reduction of illegal or high-risk behaviors;
  - f. Reduction of unplanned parenting; and
  - g. Reduction of homelessness.
3. The agency shall conduct a department-approved outcomes survey for each client upon entry, exit, and six months following exit from the supervised independent living program.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-11. Employee qualifications.**

1. The agency shall employ supervised independent living program staff with sufficient qualifications to enable the supervised independent living program staff to perform the agency's fiscal, clerical, and maintenance functions associated with operating the program.
2. The supervised independent living program shall comply with the following minimum employee-to-client ratio requirements:
  - a. No fewer than one part-time program administrator for a supervised independent living program serving less than thirty clients or a full-time program administrator for a program serving thirty or more clients; and
  - b. No fewer than one supervised independent living program transition coordinator for each fifteen clients.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

**75-03-41-12. Program administrator.**

The agency shall designate a program administrator to oversee the agency's supervised independent living program.

1. The agency clearly shall define, in writing, the responsibilities of the program administrator. At a minimum, the program administrator's responsibilities shall include:
  - a. Planning and coordinating the development of policies and procedures governing the supervised independent living program;
  - b. Ensuring the governing body is kept informed of matters affecting the supervised independent living program's finances, operation, and provision of services;
  - c. Ensuring employment of qualified staff and the administration of the supervised independent living program's employee and nonemployee policies;
  - d. Ensuring the supervised independent living program and its services are made known to the community;
  - e. Maintaining the policies and procedures required by this chapter in written form;
  - f. Maintaining a current organizational chart representing program authority; and
  - g. Supervising, evaluating, and monitoring the work progress of the program staff.
2. The program administrator must have a bachelor's degree in business, public administration, or a behavioral science field and have four years of related work experience.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

**75-03-41-13. Transition coordinator.**

1. The agency clearly shall define, in writing, the responsibilities of the supervised independent living program transition coordinator. At a minimum, responsibilities must include:
  - a. Performance of intake services;
  - b. Provide client case management and coordination of services;
  - c. Referral of resources to assist clients;
  - d. Overall management of the client's transition plan;
  - e. Documentation of ongoing communications and case activity for each client;
  - f. Competencies necessary to implement an individualized transition care plan for each client; and
  - g. Competencies to provide group services, if applicable to the program.
2. The transition coordinator must have a bachelor's degree in social work or related human service field, be licensed as required by the field of practice, and have two years previous paid or unpaid work experience with children or families.

3. The agency shall have sufficient transition coordinators employed to meet minimum employee-to-client ratios required by this chapter.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-14. Nonemployees.**

An agency that utilizes nonemployees who regularly work directly with clients shall:

1. Require nonemployees be at least two years older than the client;
2. Require each nonemployee to successfully complete a fingerprint-based criminal background check and a child abuse and neglect index check; and
3. Detail policy and procedure specific to nonemployees, including:
  - a. Description of duties and specify responsibilities for nonemployee positions;
  - b. Checking personal references before placement as a nonemployee;
  - c. Designating an employee to supervise and evaluate nonemployees;
  - d. An orientation plan that includes education on the legal requirements for confidentiality, training in the philosophy of the agency, and the needs of clients served by the supervised independent living program; and
  - e. A plan for required trainings.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-15. Professional development.**

1. The agency shall ensure employees receive training, as applicable to their position, and in current program and service delivery specific to transition to adulthood. All employees in contact with clients must receive at least fifteen hours of training per year with evidence of completion in the employee personnel file.
2. Prior to a new employee working independently with clients, the agency shall provide orientation training to the employee covering the following areas, with evidence of completion present in the employee personnel file:
  - a. Overall agency philosophy and program goals;
  - b. Review of administrative procedures, policy, and protocols;
  - c. Review of personnel policies;
  - d. Review of programs and services, policy, and protocols;
  - e. Nature of clients' emotional and physical needs;

- f. Expected employee conduct toward clients and expected client conduct;
- g. Overview of trauma and trauma informed transition into adulthood;
- h. Review protocol for incident reporting;
- i. Review client rights and grievance procedures;
- j. Identification and reporting of child abuse and neglect;
- k. Review suicide prevention, including signs and agency response measures;
- l. Review disaster planning;
- m. Review confidentiality standards;
- n. Review procedures for reporting a runaway or missing individual;
- o. Emergency medical procedures;
- p. Review procedures for client searches, if applicable for the setting; and
- q. Review child abuse and neglect mandated reporter policy and offer training.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-16. Personnel files.**

1. The agency shall maintain an individual personnel file on each employee. The employee personnel file must include:
  - a. File inventory detailing first and last date of employment, reason employment ended, training totals per year, and performance evaluation dates due;
  - b. Application for employment including a record of previous employment;
  - c. Copy of the initial fingerprint-based criminal background check;
  - d. Copy of annual child abuse and neglect index findings;
  - e. Copy of motor vehicle operator's license record, if applicable to duties;
  - f. Copy of other evaluation or background checks deemed necessary by the program administrator;
  - g. Verification of any required license or qualification for the position or tasks assigned to the employee;
  - h. Evidence of the employee having read and received a copy of the law and agency procedures requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, initially upon hire and annually thereafter;
  - i. Job description specifying the employee roles and responsibilities;
  - j. Annual performance evaluations; and

k. Professional development training records consisting of name of presenter, date of presentation, topic of presentation, and length of presentation.

2. The agency shall maintain an individual personnel file on each nonemployee. The nonemployee personnel file must include:

a. Personal identification information;

b. Copy of the initial fingerprint-based criminal background check;

c. Copy of annual child abuse and neglect index findings;

d. Copy of motor vehicle operator's license record, if applicable to duties;

e. Copy of other evaluation or background checks deemed necessary by the program administrator;

f. Description of nonemployee duties;

g. Evidence of the nonemployee having read and received a copy of the law and agency procedures requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, initially upon hire and annually thereafter; and

h. Professional development training records consisting of name of presenter, date of presentation, topic of presentation, and length of presentation.

3. The agency shall adopt a policy regarding the retention of employee and nonemployee personnel files.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-17. Background checks effect on operation of agency or employment.**

1. The agency shall require an initial fingerprint-based criminal background check for each employee and nonemployee with direct contact with clients. Subsequent background checks are not required for an employee who maintains continuous employment at the agency unless the agency or the department determines a need exists to conduct a subsequent investigation.

2. The agency shall require an initial child abuse and neglect index check review including index check review in each state where the employee or nonemployee has resided in the past five years. After the initial investigation, a child abuse and neglect index check review must be repeated annually for each employee and nonemployee with direct contact with clients.

3. The agency shall submit proper paperwork for the department to perform an annual child abuse and neglect index check review on every agency employee and nonemployee. The agency shall place a copy of the results in each employee or nonemployee personnel file.

4. The agency shall make an offer of employment to an employee or an offer of placement to a nonemployee conditional upon the individual's consent to complete required background checks. The agency shall define in policy parameters specific to duties allowed while awaiting the results of the required background check.

5. The department may excuse an employee or nonemployee from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If an employee or nonemployee is excused from providing fingerprints, the department may conduct a nationwide name-based criminal history record investigation in any state in which the employee or nonemployee lived during the eleven years preceding the signed authorization for the background check.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-06.8

### 75-03-41-18. Criminal convictions.

1. An agency may not employ an employee or place a nonemployee, in any capacity that involves or permits contact between an employee or nonemployee and any client provided supervised independent living programming by the agency, an individual who is known to have been found guilty of, pled guilty to, or pled no contest to:
  - a. An offense described in North Dakota Century Code chapter 12.1-16, homicide; 12.1-17, assaults - threats - coercion - harassment; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-41, Uniform Act on Prevention of and Remedies for Human Trafficking; or in North Dakota Century Code section 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06, sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-21-01, arson; 12.1-20-12.3, sexual extortion; 12.1-22-01, robbery; or 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 12.1-31-07, endangering an eligible adult - penalty; 12.1-31-07.1, exploitation of an eligible adult - penalty; 14-09-22, abuse of child; or 14-09-22.1, neglect of child;
  - b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or
  - c. An offense, other than an offense identified in subdivision a or b, if the department determines that the individual has not been sufficiently rehabilitated.
    - (1) The department will not consider a claim that the individual has been sufficiently rehabilitated until any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, has elapsed.
    - (2) An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction, is prima facie evidence of sufficient rehabilitation.
2. The department has determined the offenses enumerated in subdivisions a and b of subsection 1 have a direct bearing on the individual's ability to serve the public in a capacity involving the provision of supervised independent living programs and services.
3. In the case of a misdemeanor simple assault described in North Dakota Century Code section 12.1-17-01, or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine the individual has



been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction. The department may not be compelled to make such determination.

4. The department may discontinue processing a request for a criminal background check for any individual who provides false or misleading information about the individual's criminal history.
5. An individual is known to have been found guilty of, pled guilty to, or pled no contest to an offense when it is:
  - a. Common knowledge in the community verified by source documents;
  - b. Acknowledged by the individual; or
  - c. Discovered by the agency or department as a result of a background check.
6. An agency shall establish written policies and engage in practices that conform to those policies, to effectively implement this section, North Dakota Century Code section 50-11-06.8, and subsection 4 of North Dakota Century Code section 50-11-07.
7. An agency shall establish written policies specific to how the agency shall proceed if a current employee or nonemployee is known to have been found guilty of, pled guilty to, or pled no contest to an offense.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-06.8

#### **75-03-41-19. Child abuse and neglect reporting.**

1. Upon hire and annually thereafter, all agency employees and nonemployees shall certify having read the law requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, and having read and received a copy of the agency's written child abuse and neglect procedures.
2. Each agency offering supervised independent living programming to clients with the client's own children, shall adopt written policies and procedures requiring employees and nonemployees to report cases of suspected child abuse or neglect. The procedures must include the following statement: "All agency employees and nonemployees shall comply with North Dakota Century Code Chapter 50-25.1, child abuse and neglect. Therefore, it is the policy of this agency that if any employee or nonemployee who knows or reasonably suspects that a child of a client whose health or welfare has been, or appears to have been, harmed as a result of abuse or neglect, that employee or nonemployee shall immediately report this information to the department. Failure to report this information in the prescribed manner constitutes grounds for dismissal from employment or placement of nonemployee and referral of the employee or nonemployee to the office of the state's attorney for investigation of possible criminal violation."
3. The agency's policies and procedures must describe:
  - a. To whom a report is made;
  - b. When a report must be made;



- c. The contents of the report;
  - d. The responsibility of each individual in the reporting chain;
  - e. The status and discipline of an employee or nonemployee who fails to report suspected child abuse or neglect; and
  - f. The status of the employee or nonemployee while the report is being assessed; if they are the subject of the report.
4. An agency shall establish written policies specific to how the agency shall proceed when a current employee or nonemployee is known to be:
- a. Involved in any capacity in a reported incident of institutional child abuse or neglect; or
  - b. The subject of a services-required decision in a child abuse or neglect report that occurred outside of the agency.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-20. Supervised independent living setting.**

1. An agency licensed to provide supervised independent living programming may engage in service delivery based on different housing options, referenced as a supervised independent living setting. The agency is not required to offer each setting and shall specify during application and in policy which setting the agency shall provide. The agency shall have defined criteria and policy specific to clients eligible for each setting. The agency may own, lease, or contract with another person to provide a setting. Setting may include:
- a. Individual apartment: an individual suite or shared apartment unit located within a building serving one or multiple clients, each with a private bedroom and a private or shared bathroom, living space, and kitchen facilities designed as a residence. This setting may include onsite program management.
  - b. Shared housing: a single-family residence serving clients living cooperatively as an unrelated family in a house each with a private bedroom. If a client has a child of their own, the shared housing accommodations must meet the needs of all individuals residing in the home. This setting may include onsite program management.
  - c. College dorm room: a room in a building provided by a college or university containing several private or semiprivate bedrooms for housing a number of individuals in a setting whose inhabitants are in school. This includes dorms on- or off-campus and may include onsite program management.
2. A supervised independent living setting is not required to be licensed in addition to the agency license to provide supervised independent living programming.
3. A supervised independent living setting must be in compliance with all applicable provisions of state and local laws, ordinances, rules, and regulations concerning health, safety, and nondiscrimination for housing. A supervised independent living setting must be:
- a. Located in an appropriate neighborhood and so located that it is readily accessible to necessary services and adequate transportation;

b. Of sufficient size to provide proper accommodations for the client; and

c. Kept in clean and sanitary condition and in good repair providing reasonable comfort and well-being of the client.

4. Only clients accepted into the supervised independent living program may reside in a supervised independent living program setting.

5. Supervised independent living programs provided to pregnant or parenting clients and client's children shall also meet the following criteria:

a. The setting shall provide safe and adequate sleeping arrangements for the children;

b. The client's transition plan must include appropriate parent education, including certified first aid, certified cardiopulmonary resuscitation, and child care; and

c. The program policy for pregnant or parenting clients must be followed.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-21. Client eligibility.**

The supervised independent living program may be made available for a variety of clients in need of transition services. The agency shall detail in policy, clients eligible for program acceptance and the expectations of a client's ability to live independently with minimal supervision. Clients eligible for acceptance into the program may include:

1. Clients currently in the placement and care of a public agency, actively participating in continued foster care services;

2. Clients pregnant or parenting a child; or

3. Clients in need of supervised independent living programming.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-22. Program acceptance.**

Agencies licensed to provide supervised independent living programming shall define in writing policy and procedures specific to acceptance of a client into the program. The agency shall have written policies that describe the program and services offered, range of client characteristics the agency shall accept, and procedures for placement into a supervised independent living setting. The supervised independent living program policy must indicate the agency shall provide services to a client referred to the program without discrimination.

1. Application. The agency shall have written policy regarding the application required, including prospective client information, placement settings options, and financial agreements with the applicant or referral source.

2. Program acceptance committee. The agency shall have policy detailing employees on the committee, how often the committee meets, and the timeliness the committee has in responding to referrals. Before a prospective client is accepted for supervised independent living programming, the committee shall evaluate the needs of the prospective client using information and procedures described in policy and determine whether the agency can meet the identified needs of the prospective client.
3. Acceptance determination. The program acceptance committee shall complete a written, dated, and signed determination on a prospective client which includes review and identification of the prospective client's primary presenting needs. The committee shall:
  - a. Provide a written statement recommending reasons for or against program acceptance based on the ability of the agency to meet the prospective client's needs.
  - b. Provide the determination and decision within fourteen working days of receipt of the completed application; and
  - c. If denied, ensure a process for assisting the applicant or referral source in obtaining services from other agencies when the supervised independent living program is not appropriate to the applicant's needs.
4. Orientation. Each client shall receive orientation upon acceptance into the supervised independent living program. An agency employee shall:
  - a. Orient the new client and client's placement and care agency worker, if applicable, to the program;
  - b. Help the client adjust to the setting; and
  - c. Provide the client and placement and care agency, if applicable, copies of the supervised independent living setting rules, including rules on visiting, expected behavior and consequences for rule infractions, client rights and grievance and complaint procedures, with explanations of the documents.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-23. Program and services.**

1. The agency shall adopt written program policy that must include:
  - a. A description of the agency's plan for the provision of services required in this chapter, as well as assessment and evaluation procedures to be used in program planning and service delivery;
  - b. A description of the services provided by the agency, clearly stating which services are provided directly by the agency and which services are to be provided in collaboration with the placement and care agency, if the client is in public custody, or other agencies and informal supports determined appropriate for the transition plan;
  - c. The purpose or mission of the agency;
  - d. Characteristics and eligibility requirements of individuals appropriate for referral to the agency;

- e. A list of information that is required to be submitted with the referral;
- f. A description of how the agency engages in the child and family team meeting structure facilitated by the placement and care agency for a client in foster care;
- g. A description of how the agency provides services for a client to accommodate needs, either directly or through cooperative arrangements with other agencies and informal supports;
- h. A description of how the agency participates in preparing clients to develop the skills required to transition into adulthood, achieve outcomes, and live independently;
- i. A description of how the agency demonstrates that the program is guided by the best interests of the clients in all matters relating to services; and
- j. A description of how family or other adult connections shall be maintained.

2. Supervised independent living programs include the following service components to provide clients with opportunities to achieve positive outcomes and make successful transitions to self-sufficiency, which may include:

- a. Academic support;
- b. Budget financial management;
- c. Career preparation;
- d. Educational financial assistance;
- e. Employment programs or vocational training;
- f. Family support and healthy relationships;
- g. Health education and risk prevention;
- h. Housing education and home management;
- i. Needs assessment;
- j. Mentoring;
- k. Other financial assistance;
- l. Postsecondary educational support;
- m. Access to community resources and community linkages;
- n. Recreational and leisure skills; and
- o. Preparation for transition to independence.

3. The agency shall detail in writing the expectations of how often the clients are seen. Face-to-face contact with clients is required at least monthly and additional frequency is decided based on the individualized needs of the client and setting. Policy may include if the agency engages in unannounced visits.

4. The agency shall collaborate with the placement and care agency, if the client is in foster care, to request documentation for the client record and to coordinate service delivery and planning.

5. The agency shall address expectations of each supervised independent living setting. Expectations may include:

- a. House rules of the specified setting;
- b. Curfew;
- c. Personal belongings;
- d. Medication management;
- e. Clothing;
- f. Allowance;
- g. Groceries;
- h. Grievance procedures;
- i. Transportation;
- j. Utilities;
- k. Guidelines for guests and visitation;
- l. Client rights;
- m. Disaster planning;
- n. Abstain from underage consumption of alcohol;
- o. Abstain from illegal use of drugs;
- p. Abstain from illegal or criminal behavior;
- q. Abstain from violence and threats of violence; and
- r. Emergency and crisis protocols.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

**75-03-41-24. Transition plan.**

The agency shall adopt a written policy that ensures the agency shall develop a written transition plan for each client, to aid in the client's personal transition to adulthood and independence.

1. The client's transition plan must be:

- a. Developed within thirty days of acceptance to the program;
- b. Developed and reviewed with appropriate participation and informed consent of the client and placement and care agency, if applicable; and
- c. Developed in collaboration with the client and the transition coordinator and if applicable, the child and family team meeting participants on a quarterly basis.

2. The client's transition plan must include documentation of:

- a. Collaboration and communication with other agencies that are working with the client to ensure coordination of services and to carry out the client's transition plan;
- b. Services provided by the supervised independent living program and other agencies or informal supports;
- c. Completion of a needs assessment of the client;
- d. Completion of the outcomes survey;
- e. Identified measurable goals and client outcomes, including time frames for completion;
- f. Identified tasks to assist the client in meeting set goals; and
- g. The individual or entity responsible for providing the service or completing the task.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

### **75-03-41-25. Client rights.**

The agency shall have written policy indicating the agency supports the rights of clients. Specifically, the agency shall:

- 1. Respect the client;
- 2. Ensure the client is treated fairly and without discrimination;
- 3. Respect the client's family members or adult connections;
- 4. Provide safe housing;
- 5. Allow the client to take their personal items, clothing, and any gifts or possessions that have been acquired when exiting the program;
- 6. Provide referrals for the client to receive medical, vision, and dental care;
- 7. Support cultural traditions and religious faith in reasonable ways;
- 8. Support the client in participating in the development of their transition plan;
- 9. Support the client in attending and leading their quarterly foster care child and family team meeting, if applicable;
- 10. Support the participation and representation in the client's foster care judicial proceedings, if applicable; and
- 11. Outline a process that can be utilized by the client if the client feels their rights are not being protected.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

### 75-03-41-26. Client file.

Upon acceptance to the supervised independent living program, a client's case file is confidential and must be protected from unauthorized examination unless permitted or required by law or regulation. The agency shall adopt a policy regarding the retention of client files.

1. The client file must include:

- a. A file inventory with dates of acceptance into the program, referral agency, and emergency contact information;
- b. The client's full name, date of birth, and other identifying information;
- c. A photo of the client;
- d. Signed care program acceptance agreement, including financial responsibility and expectations of all parties. The agreement must indicate a clear division of responsibility between the agency, client, and the placement and care agency, if applicable;
- e. If the client is in continued foster care services, a current court order establishing the authority granted to the placement and care agency;
- f. If the client is in continued foster care services, a copy of the continued foster care agreement signed by all parties;
- g. A copy of the outcomes survey;
- h. A copy of the transition plan prepared by the agency and client;
- i. Transition plan progress reports, no less than quarterly;
- j. Ongoing documentation and case activity logs of face-to-face contact, electronic mails, and texts with clients; and
- k. All incident or sentinel event reports involving the client.

2. The agency shall designate an employee to review each client file at least quarterly. Documentation of the file review must be included in the client file.

3. An agency shall disclose its records to the department as requested.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-05

### 75-03-41-27. Incident and sentinel event reporting.

A client served by the agency also in foster care shall have all incident and sentinel events reported to the placement and care agency. The agency shall report sentinel events to the regional office of the department.

1. The agency shall have written policy outlining the critical incident and sentinel event reporting for all clients.

- a. An incident is an unplanned occurrence that resulted or could have resulted in injury to people or damage to property, specifically involving the general public, clients in

supervised independent living setting, or agency employees and nonemployees. An incident also can involve issues such as harassment, violence, and discrimination.

b. A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury that is not related to the natural course of a client's illness or underlying condition, including any process variation for which a recurrence would carry a significant chance of a serious adverse outcome including inappropriate sexual contact.

2. The agency immediately shall notify the client's placement and care agency when any of the following occurs involving a client in foster care:

a. An incident that requires the services of law enforcement, including:

(1) Case of a runaway or missing individual; or

(2) Criminal activity by the client placed in a supervised independent living setting; or

b. A sentinel event, including:

(1) Death of a client in foster care;

(2) Serious injury or trauma of a client in foster care, requiring medical attention;

(3) Any attempt at suicide by a client in foster care; and

(4) Any behavior involving a client in foster care, that results in a serious threatening situation of harm to others.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03

#### **75-03-41-28. Variance.**

Upon written application and good cause shown to the satisfaction of the department, the department may grant a variance regarding a specific provision of this chapter upon such terms as the department may prescribe, except no variance may permit or authorize a danger to the health or safety of any client accepted in the supervised independent living program and no variance may be granted except at the discretion of the department. An agency shall submit a written request to the department justifying the variance. A refusal to grant a variance is not subject to appeal.

**History:** Effective October 1, 2019.

**General Authority:** NDCC 50-06-05.1, 50-11-03

**Law Implemented:** NDCC 50-06-05.1, 50-11-03