CHAPTER 45-06-07
MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

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45-06-07-01. Applicability and scope.

This chapter applies to all health maintenance organizations that are required to obtain a certificate of authority in this state. In the event of conflict between the provisions of this chapter and the provisions of any other chapter issued by the commissioner, the provisions of this chapter shall be controlling as to health maintenance organizations.

History: Effective July 1, 1994.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-06-07-02. Effective date.

1. All group and individual contracts written or issued on or after December 31, 1993, must conform with the provisions of these rules.

2. Group or individual contract or evidence of coverage may not be reissued, renewed, amended, or extended in this state on or after December 31, 1993, unless it complies with this chapter. A group or individual contract or evidence of coverage approved before December 31, 1993, must be deemed to be reissued, renewed, amended, or extended on the date the health maintenance organization changes the terms of the group or individual contract or evidence of coverage or adjusts the premiums charged. Such group or individual contracts or evidence of coverage must comply with this chapter when amended but in no event later than June 30, 1995.

History: Effective July 1, 1994.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-06-07-03. Definitions.

Group or individual contract or evidence of coverage delivered or issued for delivery to any person in this state by a health maintenance organization required to obtain a certificate of authority in this state may not contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section. Definitions other than those in this section may be used as appropriate, providing that they do not contradict these requirements. All definitions used in the group or individual contract and evidence of coverage must be in alphabetical order. As used in this chapter and as used in the group or individual contract and evidence of coverage:

1. "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory, and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services, or long-term rehabilitation treatment.

2. "Copayment" means the amount an enrollee must pay in order to receive a specific service that is not fully prepaid.

3. "Deductible" means the amount an enrollee is responsible to pay out of pocket before the health maintenance organization begins to pay the costs or provide the services associated with treatment.

4. "Eligible dependent" means any member of a subscriber's family who meets the eligibility requirements set forth in subsection 2 of section 45-06-07-04.

5. "Emergency care services" means:

   a. Within the service area: covered health care services rendered by affiliated or nonaffiliated providers under unforeseen conditions that require immediate medical attention. Emergency care services within the service area include covered health care services from nonaffiliated providers only when delay in receiving care from the health maintenance organization could reasonably be expected to cause severe jeopardy to the enrollee's condition.

   b. Outside the service area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the health maintenance organization's service area.

6. "Enrollee" means an individual who is covered by a health maintenance organization.

7. "Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contractholder.

8. "Extension of benefits" means the continuation of coverage of a particular benefit provided under a group or individual contract following termination with respect to an enrollee who is totally disabled on the date of termination.

9. "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

10. "Group contract" means a contract for health care services which by its terms limits eligibility to enrollees of a specified group. The group contract may include coverage for dependents.

11. "Group contractholder" means the person to whom a group contract has been issued.

12. "Health maintenance organization" means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles.

13. "Hospital" means a duly licensed institution that provides general and specialized inpatient medical care. The term "hospital" does not include a convalescent facility, nursing home, or any institution or part of an institution which is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged.

14. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include coverage for dependents of the subscriber.

15. "Medical necessity" or "medically necessary" means appropriate and necessary services as determined by any provider affiliated with the health maintenance organization which are rendered to an enrollee for any condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness or injury and are not provided only as a convenience. This does not preclude the health maintenance organization from establishing standards by which providers make their decisions as to what is medically necessary or from penalizing providers for failure to meet these standards. In the case of emergency medical services, the health maintenance organization has the right to make the final determination of whether services should be covered.

16. "Nonbasic health care services" means any health care services, other than basic health care services, that may be provided in the absence of basic health care services.

17. "Out-of-area services" means the health care services that a health maintenance organization covers when its enrollees are outside of the service area.

18. "Participating provider" means a provider as defined in this section who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

19. "Physician" means a duly licensed doctor of medicine or osteopathy practicing within the scope of such a license.

20. "Primary care physician" means a physician who supervises, coordinates, and provides initial and basic care to enrollees, and who initiates their referral for specialist care and maintains continuity of patient care.

21. "Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

22. "Replacement coverage" means the benefits provided by a succeeding carrier.

23. "Service area" means the geographical area as approved by the commissioner within which the health maintenance organization provides or arranges for health care services that are available and accessible to enrollees.

24. "Skilled nursing facility" means a facility that is operated pursuant to law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed physician.

25. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

26. "Supplemental health care services" means any health care services that are provided in addition to basic health care services.

History: Effective July 1, 1994.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-06-07-04. Requirements for contracts and evidence of coverage.

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

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

2. **Eligibility requirements.**

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

   b. A group or individual contract or evidence of coverage may not contain any provision excluding or limiting coverage for a newborn child or adopted child. Medically diagnosed congenital defects and birth abnormalities must be treated the same as any other illness or injury for which coverage is provided. The group or individual contract and evidence of coverage may require that notification of birth of a newborn childor the placement for adoption of a child and payment of any required premium must be furnished to the health maintenance organization within thirty-one days after the date of birthor placement for adoption in order to have coverage continue beyond such thirty-one-day period. The health maintenance organization is entitled to premium for the first thirty-one days of coverage, unless the coverage is rejected by the subscriber prior to the birthor placement for adoption of the child.

   c. The definition of an eligible dependent must include:

      (1) The spouse of the subscriber.

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

         (a) Has not reached age twenty-two;

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

         (c) Has reached agetwenty-two but who is incapable of self-support because of mental retardation, mental illness, or physical incapacity which began before

the child reached age twenty-two, and who is chiefly dependent upon the subscriber for support and maintenance.

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

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

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

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

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

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

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

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

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

8. **Enrollee termination.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Any required notice to the health maintenance organization.

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

c. Any requirements for filing proper proofs of loss.

d. Any time limit of payment of claims.

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

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

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

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

13. **Conversion of coverage.**

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

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

(2) Upon termination of the group contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16. **Subrogation for injuries caused by third parties.** The group or individual contract and evidence of coverage may not contain any provisions concerning subrogation for injuries caused by third parties unless the wording has been approved by the commissioner.

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

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

attached to the contract. However, the evidence of coverage may be attached to and made a part of the group contract.

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

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

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

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

23. **Grace period.**

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

    b. During the grace period:

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

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

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

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

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

25. **Right to examine contract.** An individual contract must contain a provision stating that a person who has entered into an individual contract with a health maintenance organization must be permitted to return the contract within ten days of receiving it and to receive a refund of the premium paid if the person is not satisfied with the contract for any reason. If the contract is returned to the health maintenance organization or to the agent through whom it

was purchased, it is considered void from the beginning. However, if services are rendered or claims are paid for such person by the health maintenance organization during the ten-day examination period and the person returns the contract to receive a refund of the premium paid, the person must be required to pay for such services.

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

45-06-07-05. Prohibited practices.

1. **Preexisting conditions.**

   a. A health maintenance organization may impose a preexisting condition exclusion only if:

      (1) The exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage;

      (2) The exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee for coverage offered to a small employer pursuant to North Dakota Century Code chapter 26.1-36.3, after the effective date of coverage;

      (3) In the case of group contracts, the exclusion does not relate to pregnancy as a preexisting condition; and

      (4) In the case of group contracts, the exclusion does not relate to genetic information as a preexisting condition in the absence of a diagnosis of a condition related to such information.

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

   c. A health maintenance organization shall reduce any time period applicable to a preexisting condition, for a contract by the aggregate of periods the individual was covered by qualifying previous coverage, if the qualifying previous coverage as defined in North Dakota Century Code section 26.1-36.3-01 is continuous until at least sixty-three days before the effective date of the new coverage. Any waiting period applicable to an individual for coverage under a health maintenance organization contract may not be taken into account in determining the period of continuous coverage. A health maintenance organization shall credit coverage in the same manner as provided by North Dakota Century Code section 26.1-36.3-06 and the rules adopted by the commissioner pursuant thereto.

2. **Unfair discrimination.** A health maintenance organization may not unfairly discriminate against any enrollee or applicant for enrollment on the basis of the age, sex, race, color, creed, national origin, ancestry, religion, marital status, or lawful occupation of an enrollee, or because of the frequency of utilization of services by an enrollee. However, a health

maintenance organization is not prohibited from setting rates or establishing a schedule of charges in accordance with relevant actuarial data.

3. **Prohibiting discrimination against enrollees and beneficiaries based on health status-related factors.**

   a. A health maintenance organization may not establish rules for eligibility including continued eligibility of any individual to enroll under the terms it group contracts based on a health status-related factor, as defined in subsection 20 of North Dakota Century Code section 26.1-36.3-01.

   b. This section shall not be construed to:

      (1) Require a health maintenance organization offering group contracts to provide particular benefits other than those provided under the terms of the contract; or

      (2) To prevent a health maintenance organization from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled under the contract.

   c. A health maintenance organization offering group contracts may not require an individual as a condition of enrollment or continued enrollment under the plan to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled under the contract based on any health status-related factor, as defined in subsection 20 of North Dakota Century Code section 26.1-36.3-01.

   d. This subsection shall not be construed to:

      (1) Restrict the amount that an employer may be charged for the contract; or

      (2) Prevent a health maintenance organization offering group contracts from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

History: Effective July 1, 1994; amended effective April 1, 1996; December 1, 1997.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-06-07-06. Services.

1. **Access to care.**

   a. A health maintenance organization shall establish and maintain adequate arrangements to provide health services for its enrollees, including:

      (1) Reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility;

      (2) Reasonable hours of operation and after-hours services;

      (3) Emergency care services available and accessible within the service area twenty-four hours a day, seven days a week; and

      (4) Sufficient providers, personnel, administrators, and support staff to assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees.

b. A health maintenance organization shall make available to each enrollee a primary care physician and provide accessibility to medically necessary specialists through staffing, contracting, or referral. A health maintenance organization shall provide for continuity of care for enrollees referred to specialists.

c. A health maintenance organization shall have written procedures governing the availability of services utilized by enrollees, including at least the following:

(1) Well-patient examinations and immunizations;

(2) Emergency telephone consultation on a twenty-four hours per day, seven days per week basis;

(3) Treatment of emergencies;

(4) Treatment of minor illness; and

(5) Treatment of chronic illnesses.

2. **Basic health care services.** A health maintenance organization shall provide, or arrange for the provision of, as a minimum, basic health care services that must include the following:

a. Emergency care services, as defined in subsection 5 of section 45-06-06-03.

b. Inpatient hospital services, meaning medically necessary hospital services including room and board; general nursing care; special diets when medically necessary; use of operating room and related facilities; use of intensive care units and services; x-ray, laboratory, and other diagnostic tests; drugs, medications, biologicals, anesthesia, and oxygen services; special nursing when medically necessary; physical therapy, radiation therapy, and inhalation therapy; administration of whole blood and blood plasma; and short-term rehabilitation services.

c. Inpatient physician care services, meaning medically necessary health care services performed, prescribed, or supervised by physicians or other providers including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services.

d. Outpatient medical services, meaning preventive and medically necessary health care services provided in a physician's office, a nonhospital-based health care facility, or at a hospital. Outpatient medical services must include diagnostic services; treatment services; laboratory services; x-ray services; referral services; and physical therapy, radiation therapy, and inhalation therapy. Outpatient services must also include preventive health services that must include at least a broad range of voluntary family planning services, well-child care from birth, periodic health evaluations for adults, screening to determine the need for vision and hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice.

3. **Out-of-area services and benefits.**

a. Out-of-area services are subject to the same copayment requirements set forth in subsection 6 of section 45-06-07-04.

b. When an enrollee is traveling or temporarily residing out of a health maintenance organization's service area, a health maintenance organization shall provide benefits for reimbursement for emergency care services and transportation which is medically necessary and appropriate under the circumstances to return the enrollee to a health maintenance organization provider, subject to the following conditions:

(1) The condition could not reasonably have been foreseen;

(2) The enrollee could not reasonably arrange to return to the service area to receive treatment from the health maintenance organization's provider;

(3) The travel or temporary residence must be for some purpose other than the receipt of medical treatments; and

(4) The health maintenance organization is notified by telephone within twenty-four hours of the commencement of such care unless it is shown that it was not reasonably possible to communicate with the health maintenance organization in such time limits.

c. Services received by an enrollee outside of the health maintenance organization's service area will be covered only so long as it is unreasonable to return the enrollee to the service area.

4. **Supplemental health care services.** In addition to the basic health care services required to be provided in subsection 2, a health maintenance organization may offer to its enrollees any supplemental health care services it chooses to provide. Limitations as to time and cost may vary from those applicable to basic health care services.

5. **Nonbasic health care services.** A health maintenance organization may offer nonbasic health care services to any group or individual on a prepaid basis, subject to the same conditions as for supplemental health care services, as described in subsection 4, except that the health maintenance organization need not provide basic health care services as a condition to providing nonbasic health care services.

History: Effective July 1, 1994.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-06-07-07. Other requirements.

1. **Description of providers.**

a. A health maintenance organization shall provide its subscribers with a list of the names and locations of all of its providers no later than the time of enrollment or the time the group or individual contract and evidence of coverage are issued and upon reenrollment. If a provider is no longer affiliated with a health maintenance organization, the health maintenance organization shall provide notice of such change to its affected subscribers within thirty days. Subject to the approval of the commissioner, a health maintenance organization may provide its subscribers with a list of providers or provider groups for a segment of the service area. However, a list of all providers must be made available to subscribers upon request.

b. Any list of providers must contain a notice regarding the availability of the listed primary care physicians. Such notice must be in not less than twelve-point type and be placed in a prominent place on the list of providers. The notice must contain the following or similar language:

> Enrolling in [name of health maintenance organization] does not guarantee services by a particular provider on this list. If you wish to receive care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for [name of health maintenance organization].

2. **Description of the services area.** A health maintenance organization shall provide its subscribers with a description of its service area no later than the time of enrollment or the time the group or individual contract and evidence of coverage is issued and upon request thereafter. If the description of the service area is changed, the health maintenance organization shall provide at such time a new description of the service area to its subscribers.

3. **Copayments and deductibles.** A health maintenance organization may require copayments or deductibles of enrollees as a condition for the receipt of specific health care services. Copayments for basic health care services must be shown in the group or individual contract and evidence of coverage as a specified dollar amount. Copayments and deductibles must be the only allowable charge, other than premiums, assessed to subscribers for basic, supplemental, and nonbasic health care services.

4. **Grievance procedure.**

   a. A grievance procedure must be established and maintained by a health maintenance organization to provide reasonable procedures for the prompt and effective resolution of written grievances.

   b. A health maintenance organization shall provide grievance forms to be given to enrollees who wish to register written grievances. Such forms must include the address and telephone number to which grievances must be directed and must also specify any required time limits imposed by the health maintenance organization.

   c. The grievance procedure must provide for written acknowledgment of grievances and grievances to be resolved or to have a final determination of the grievance by the health maintenance organization within a reasonable period of time, but not more than ninety days from the date the grievance is received. This period may be extended in the event of a delay in obtaining the documents or records necessary for the resolution of the grievance, or by the mutual written agreement of the health maintenance organization and the enrollee.

   d. Prior to the resolution of a grievance filed by a subscriber or enrollee, coverage may not be terminated for any reason which is the subject of the written grievance, except if the health maintenance organization has, in good faith, made a reasonable effort to resolve the written grievance through its grievance procedure and coverage is being terminated as provided for in subsection 8 of section 45-06-07-04.

   e. If enrollee's grievances may be resolved through a specified arbitration agreement, the enrollee must be advised in writing of the enrollee's rights and duties under the agreement at the time the grievance is registered. Any such agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration. Any health maintenance organization that makes such binding arbitration a condition of enrollment must fully disclose this requirement to its enrollees in the group or individual contract and evidence of coverage.

History: Effective July 1, 1994.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-06-07-08. Penalties.

Any violation of this chapter is subject to the penalties as provided for in North Dakota Century Code title 26.1 and any other applicable law of this state.

History: Effective July 1, 1994.
General Authority: NDCC 26.1-18.1

Law Implemented: NDCC 26.1-18.1

45-06-07-09. Severability.

If any provision of this chapter or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the chapter and the application for such provision to other persons or circumstances is not affected thereby.

History: Effective July 1, 1994.
General Authority: NDCC 26.1-18.1
Law Implemented: NDCC 26.1-18.1

45-06-07-10. Producer compliance.

Any health maintenance organization producer under this chapter is subject to the requirements and provisions of North Dakota Century Code chapter 26.1-26.

History: Effective July 1, 1998.
General Authority: NDCC 26.1-18.1-16
Law Implemented: NDCC 26.1-18.1-16