



North Dakota
Insurance Department
Adam W. Hamm, Commissioner

May 5, 2011

Mr. Gary Cohen
Acting Director, Office of Oversight
Office of Consumer Information and Insurance Oversight
Via electronic mail

Dear Mr. Cohen:

This is in response to your April 18, 2011 letter requesting additional information relating to North Dakota's Medical Loss Ratio Adjustment Request. Attached you will find the requested information.

Please note: Sanford Health Plan, Heart of American Health Plan and Companion Life have not responded to our request for further information to answer your questions; however, if the Department receives responses from these companies, they will be promptly forwarded to you.

Please let us know if you need additional information.

Sincerely,



Adam Hamm
Insurance Commissioner

Enclosures

Letter #1

Re: Clarification questions

- 1. Title 45 CFR § 158.343 provides that any State that submits a request for adjustment to the MLR standard may hold a public hearing with respect to its application. Please indicate whether the NDID has provided a forum for public input regarding the NDID's application for an adjustment to the MLR standard. If there has been public input (other than the survey of health insurance companies noted in the NDID application and the letter from the National Association of Insurance and Financial Advisors of North Dakota included as Attachment C to that application), please provide copies of the correspondence, comments or other input the NDID has received in connection with its request for an adjustment to the MLR standard.**

NDID received a letter April 4, 2011 from Blue Cross Blue Shield of North Dakota's board of directors that includes comments about the MLR adjustment request. See Attachment 1.

No public forum has been held. However, the MLR application was posted on the Department's website and it was also emailed to a group of the Department's stakeholders.

- 2. Page 1 of the NDID's letter notes that it has had "many discussions with insurance carriers, the producer community and other stakeholders on the MLR percentage." Please identify who those other stakeholders were.**

Other stakeholders include legislators, media, provider groups, insurance industry organizations, children's health organizations, rural health organizations, medical associations and other state agencies.

- 3. As part of the NDID's process of deciding whether to request an MLR waiver, page 1 of the letter portion of the NDID's application states that "the Insurance Department conducted a survey of health insurance companies offering individual products in North Dakota [...] Eight companies were contacted; six responded." According to page 2 of the NDID's letter, "North Dakota currently has nine companies selling health insurance policies." Please identify the eight companies included in the survey, and identify and explain why the ninth company was not included in the survey.**

The following companies were contacted: American Republic, World Insurance, Companion Life, Heart of America Health Plan, Blue Cross Blue Shield of North Dakota, Medica, Sanford Health Plan and Assurant. Assurant is the parent company of John Alden Life Insurance Company and Time Insurance Company. When counted separately, the two Assurant companies bring the total number of companies doing business in the state to nine; however, just one survey was sent to Assurant as the parent company. That is the discrepancy between eight companies being sent the survey and nine doing business in North Dakota.

Note: Heart of America Health Plan and Companion Life were the two companies that did not respond.

- 4. Page 1 of the NDID’s letter notes that two companies’ responses to the survey described in Item 3 above included statements that “the absence of an MLR waiver may cause carriers to terminate existing blocks of business and leave the market.” In addition, page 4 of the NDID’s letter notes that “One carrier has stated that without a transition period, carriers may choose to terminate existing blocks of business to avoid future solvency issues.” Please identify the carriers that made these statements and clarify whether carriers have identified any specific issues that they believe may terminate existing blocks of business.**

“The absence of an MLR waiver may cause carriers to terminate existing blocks of business and leave the market.” This comment was made by American Republic Insurance Company and World Insurance Company.

“One carrier has stated that without a transition period, carriers may choose to terminate existing blocks of business to avoid future solvency issues.” This comment was made by American Republic Insurance Company and World Insurance Company.

- 5. Page 1-2 of the NDID’s letter notes that one of the surveyed issuers stated that it “saw no need for a phased-in approach” to the 80 percent MLR standard, “anticipating it would meet the requirement throughout 2011-13.” Please identify that issuer.**

Blue Cross Blue Shield of North Dakota

- 6. Page 2 of the NDID’s letter states that, of the nine companies selling individual insurance in the State, “Two of these companies were not selling in the state two years ago.” Please identify these two companies, both of which entered the North Dakota individual market after the North Dakota legislature lowered the State’s MLR from 65% to 55%. If not already provided in the table labeled “Medical loss ratios” in Attachment B, please provide the MLR of these two companies for each year since their entry into the North Dakota individual market.**

Medica Insurance Company and Sanford Health Plan were not selling in North Dakota two years ago. MLR information for Medica was included in Attachment B.

- 7. Page 2 of the NDID’s letter states that the addition of two new insurers and six new individual policies in the State over the last two years “indicates a strengthening in the individual market over the past several years” that “has been very advantageous for consumers in North Dakota.” Please provide any data that demonstrate the ways in which consumers have benefited from increased competition in the State’s individual market over the last several years, such as data demonstrating that premiums have decreased or increased less than projected over the last several years.**

Product offerings that weren’t available in the individual health insurance market before are now available to consumers. The important impact of new companies in the

individual health insurance market is choice for consumers. Choice for consumers is very advantageous at a time when health insurance expenditures are economically more important than ever.

8. Please explain the process, calculations and assumptions used to generate the figures provided in the table labeled “Estimated PPACA MLR for individual market business in North Dakota” in Attachment B.

John Alden

As of 12/31/2010, John Alden membership in North Dakota was 658 lives in the individual market. We do not expect North Dakota to be credible for MLR calculations in 2011.

Time Insurance Company

The 2009 and 2010 estimates are based on each year’s premiums and claims data, adjusted by values for quality improvement expenses and taxes, licenses and fees, which were determined using data from the 2010 Supplemental Health Care Exhibit. A credibility adjustment is also included based on each year’s enrollment and average deductible. The 2011 estimates are defined in more detail below.

World Insurance Company and American Republic Insurance Company

1. Incurred claims were divided by earned premiums to arrive at an incurred loss ratio for each applicable year.
2. Incurred claims were increased by 3% of earned premiums for assumed quality improvement expenses.
3. Earned premiums were decreased by 2.25% for assumed premium taxes, licenses, and fees.
4. An adjusted loss ratio was calculated by dividing the incurred claims from step 2 by the earned premiums in step 3.
5. Based on the life years exposed, the applicable credibility adjustment was determined.
6. Based on the average deductible in force, the applicable deductible factor was determined.
7. The credibility adjustment from step 5 was multiplied by the deductible factor from step 6 to determine the total credibility adjustment.
8. The credibility adjustment from step 7 was added to the adjusted loss ratio from step 4 to determine the PPACA MLR for North Dakota.

* Please note that the numbers provided were estimates. Also note that at the time we estimated the 2010 PPACA MLR, we did not have full year 2010 data available and estimated the 2010 numbers based on results through 9/30/2010.

Blue Cross Blue Shield of ND

The estimated PPACA MLR for individual market business for 2009 was calculated using incurred claims with a three month paid run out (estimated to be 98.7% complete) plus remaining estimated IBNR. Claims were reduced by the non-group conversion

subsidy calculated from small and large group business (typically 1% of premium). Expenses to improve health care quality were estimated at .25% of gross income. Total estimated claims plus quality expenses were divided by actual gross income less premium taxes. A credibility adjustment factor of 1.45% was applied for life years between 25,000 and 50,000. This produced a 2009 estimated MLR of 107.6% for individual business. The 2010 individual MLR of 110.2% was calculated using 2010 paid claims plus estimated IBNR. The 2009 factors used for IBNR, non-group conversion subsidy, health care quality expenses and credibility were also used for 2010. Actual year-to-date income through November 2010 was used with December 2010 income estimated.

Medica Insurance Company

In accordance with PPACA requirements, pricing effective on 1/1/2011 was set to achieve an 80% target loss ratio. As stated in the MLR survey, MIC entered the ND market in late-2009 and historical experience is limited, so MIC used MN for a proxy for several pricing assumptions. MIC projected actual-to-expected results based on its blended MN, ND, and SD business over the effective range of the requested pricing.

- 9. As we read N.D.C.C. § 26.1-36.4-07, it appears that all issuers in the individual market in North Dakota are required to offer a “basic health benefit plan” and a “standard health benefit plan.” If so, please provide the total enrollment in these plans by issuer, the premiums for these plans and a description of the benefits offered under these plans.**

There are no individual basic or standard health benefits plans in force that the Department is aware of. These plans were originally designed for use in the small employer market in conjunction with the small employer carrier reinsurance program, which has since been discontinued for lack of use. Although the basic and standard benefit plans are required to be offered under statute, the plans are not popular due to their cost and benefit design (which has not changed since they were designed in 1994 and the Commissioner was not granted authority to make revisions to the plans). These plans are not guaranteed-issue in the individual market. See Attachments 2a and 2b (sample prototype plans).

- 10. As we read N.D.C.C. § 26.1-36-12.5, it appears that issuers in the individual market in North Dakota are allowed to offer consumers a “basic health insurance policy” exempt from State-mandated benefits. Please indicate which, if any, plans from the data provided in Attachment A to the application qualify as “basic health insurance polici[es].” If other plans not listed in Attachment A to the application qualify for exemptions from State-mandated benefits, please identify policies and provide the enrollment in the policies.**

None qualify.

- 11. As we read N.D.C.C. § 26.1-36.4-04, in addition to HIPAA portability requirements, all issuers in North Dakota are required to credit prior coverage under an individual policy towards a pre-existing condition exclusion period if there was no**

break in coverage of more than 63 days. Please explain the applicability of this provision to the North Dakota individual market and describe how creditable coverage is defined.

The portability provision required by N.D.C.C. § 26.1-36.4-04 is the same as for HIPAA except the definition of credible coverage is qualifying previous coverage. This is referenced to the definition found in the small employer N.D.C.C. § 26.1-36.3-01(28).

12. Please clarify the calendar year that pertains to the data in the table labeled “Premium and enrollee information for all individual major medical products in ND” in Attachment A. If the data are for 2009, please explain why the sums of the premiums for each of the first three insurance companies (Medica, American Republic and World) listed in the table “Premium and enrollee information for all individual major medical products in ND” are not equal to the 2009 figures given for those companies in the Attachment A table “Total earned premium on individual market products in North Dakota.”

All numbers are from 2009, except Medica’s numbers are from 2010.

In the initial application, numbers in the table “Premium and enrollee information for all individual major medical products in ND” for American Republic and World Insurance Companies were annualized premiums instead of earned premiums. Following are the earned premium numbers for those companies and products:

Company	Product	Premium	# individual enrollees
American Republic Insurance Company	Major Medical Revamp	\$379,473	322
	ARS Value Choice	2,722	1
	Pinnacle CareAdvantage Complete	6,786	4
	UltraCare Medical Expense/CareGuard	124,494	74
	UltraCare AdvantageOne HSA	342,287	124
	UltraCare Preferred Gen 3	336,887	48
	UltraCare Preferred MSA Gen 3	114,522	18
	UltraComp Preferred Value	366,507	81
	UltraCare Preferred Gen 1	118,128	20
World Insurance Company	UltraCare I, II, MajMed GR	72,711	6
	Major Medical Revamp	\$72,754	517
	Choice	163,998	14
	Combined Plus Filing	17,183	1
	MAM Choice	190,569	15
	WorldCare HDHP/HD Adv – Gen 4	3,395	3
	Short Term Major Medical	2,482	1

13. In the Attachment A table “Total agent and broker commissions on individual market business in North Dakota,” Time Insurance Company’s 2010 commissions are marked as “n/a.” Please confirm that Time Insurance Company did not pay commissions in 2010. If Time did pay commissions, please provide that data.

Commissions from the 2010 SHCE (Part I, line 10.2, column 1 (for individual))
Time Insurance Co.: \$1,020,575

Also: Commissions from the 2010 SHCE (Part I, line 10.2, column 1 (for individual))
John Alden Life Insurance Co.: \$78,403

Letter #2

Re: Information needed

1. Page two of North Dakota’s application states that “North Dakota currently has nine companies selling individual health insurance policies.” However, Attachments A, B, and D provided data for only six insurers. For the three other issuers for which no data was included, please provide the number of individual enrollees by product, available premium data by product and individual health insurance market share within the State, as required by 45 CFR §158.321(d)(1).

Company	2009		
	Enrollees	Premium	Market share
Companion Life Insurance Company	292	\$650,712	0.64%
Heart of America HMO	283	\$885,797	0.87%
Sanford Health Plan	0	0	0

2. If any of the three issuers for which information is provided in response to Question 1 provide coverage in the North Dakota individual market to more than 1,000 enrollees, please also provide, as required by 45 CFR § 158.321(d)(2), the issuers: total earned premium, reported MLR, estimated MLR, commission expenses, estimated rebate, net underwriting profit, after tax profit and profit margin, RBC and whether the issuer has provided notice of exit.

None of the issuers cover more than 1,000 enrollees.

3. For each issuer that offers coverage in the North Dakota individual market, please provide the issuer’s individual health insurance market share in North Dakota, as required by 45 CFR § 158.321(d)(1).

Company	2009 market share
American Republic Insurance Company	1.80%
Blue Cross Blue Shield of ND	75.90%
Companion Life Insurance Company	0.64%
Heart of America HMO	0.87%
John Alden Life Insurance Company	1.32%
Medica Insurance Company	0.02%
Sanford Health Plan	0%
Time Insurance Company	10.60%
World Insurance Company	0.44%

4. Title 45 CFR § 158.322(c) requires an estimate of the rebates that would be paid if the issuers offering coverage in the individual market in the State were required to meet an 80 percent MLR for the MLR reporting years for which an adjustment is needed. The North Dakota Insurance Department (NDID), on page 5 of its application, states that it is seeking an adjustment to the MLR standard for 2011, 2012 and 2013. Attachment B to the application provides the estimated rebate requirement for individual market issuers in North Dakota for the years 2009 and 2010 if issuers were required to meet an

80 percent MLR. Please provide estimates of the rebates that would be paid by each issuer in North Dakota’s individual market for the years 2011, 2012 and 2013, as required by 45 CFR § 158.322(c).

Company	Rebate estimate		
	2011	2012	2013
American Republic Insurance Company	0	0	0
Blue Cross Blue Shield of ND	0	0	0
John Alden Life Insurance Company*	n/a	n/a	n/a
Medica Insurance Company**	0	0	0
Time Insurance Company***	\$0.7-\$0.8M	n/a	n/a
World Insurance Company	0	0	0

*As of 12/31/2010 the membership in North Dakota was 658 lives in the individual market. We do not expect North Dakota to be credible for MLR calculations in 2011.

** No rebates are expected as pricing effective on 1/1/2011 was set to achieve an 80% target loss ratio. MIC is prepared to offer rebates should the introduction of additional products on 4/2010 and 1/2011 draw large amounts of newly underwritten members, but the limited ND experience and rapid ND growth MIC is currently experiencing would indicate it is premature to determine the amount of rebates on the immature block of business when pricing is set to achieve the target loss ratio.

***Nationwide, we estimate our rebates for 2011 will be \$80-\$90 million. As of 12/31/2010, North Dakota represented 0.9% of our individual medical earned premium and therefore, the estimated rebate for North Dakota is \$0.7-\$0.8 million, which would equate to an estimated PPACA MLR of 72%-73%. The actual rebate will vary based on our experience within North Dakota and it is not uncommon for there to be swings in the loss ratio of +/- 15% when based on the number of lives in your state.

We have not published any estimates for 2012 and later years. These estimates cannot be determined to a sufficient level of certainty due to the unknown elements that are involved in these calculations, including potential changes in rates, lives, percentage of new business, and regulations. However, we note that our products will be priced to achieve the 80% PPACA MLR.

5. For each issuer that provide coverage in the North Dakota individual market to more than 1,000 enrollees, please provide, as required by 45 CFR § 158.321(d)(2)(vii), the issuer’s after-tax profit and profit margin for the individual market business and consolidated business in the State.

Blue Cross Blue Shield of North Dakota

	All business	Individual	All other business
2009 after tax gain (loss)	\$10,000,000	(\$13,269,000)	\$23,269,000
2009 after tax margin	0.7%	(15.3%)	1.8%

Time Insurance Company

2009 Individual Market Profit (Loss)	(\$572,741)
2009 Individual Market Profit (Loss) Margin	(5.3%)
2009 Consolidated Profit (Loss)	(\$379,252)
2009 Consolidated Profit (Loss) Margin	(3.3%)

Medica Insurance Company

Prospectively, MIC targets 0.5% operating profit margin on its entire long-term block of business, but 2009 results produced -0.5%.

- 6. For each issuer that provides coverage in the North Dakota individual market to more than 1,000 enrollees, please indicate, as required by 45 CFR § 158.321(d)(2)(ix), whether the issuer has provided notice of exit.**

No insurers to-date have provided notice to the Department to exit the North Dakota individual health insurance market. See Attachment 1, page 6 of the PDF, for comments submitted by Blue Cross Blue Shield of North Dakota on this issue.

- 7. Please provide, as required by 45 CFR § 158.321(c), further information on the Comprehensive Health Association of North Dakota (North Dakota's high risk pool), including the specific eligibility requirements, the enrollment period, any enrollment caps or potential funding limitations, the waiting period for pre-existing conditions, and a schedule of premium rates.**

CHAND eligibility requirements: <http://www.chand.org/eligible/>

CHAND rates: <http://www.chand.org/rates/>

Potential funding limitations—none

The enrollment period for the Comprehensive Health Association of North Dakota (CHAND) is:

- 1) For a traditional and age 65 and over or disabled applicant (N.D.C.C. § 26.1-08-12(5)(a)&(c)): Within 180 days from the date of application for CHAND that written evidence has been received from an insurer that coverage has been denied, offered with an exclusionary or restrictive rider, offered at a higher rate than CHAND for comparable coverage, or reached the lifetime maximum. The lifetime maximum does not apply to an age sixty-five and over or disabled applicant.
- 2) For a HIPAA or TARRA applicant that meet those requirements as stated under N.D.C.C. § 26.1-08-12(5)(b)&(d) must apply for coverage within 63 days of termination of the qualifying coverage.

There are no enrollment caps for CHAND.

A 180-day waiting period for pre-existing conditions applies to a traditional and age sixty-five and over or disabled applicant. This waiting period may be reduced by the period covered by qualifying previous coverage if there has been a break no longer than sixty-three days since termination of the previous coverage. HIPAA and TARRA applicants are not subject to a pre-existing condition waiting period.

- 8. Attachment B to the application designates Medica Insurance Company's risk based capital ratio for 2007, 2008 and 2009 as "n/a." We understand from the footnote to the table labeled "Medical loss ratios" in Attachment B that Medica entered the North Dakota individual market in 2009. Please provide, as required by 45 CFR § 158.321(d)(2)(viii), Medica's risk-based capital ratio for 2009.**

543.4%

- 9. Attachment B to the application designates Time Insurance Company's estimated MLR for the individual market business in North Dakota as "n/a" for 2009 and 2010, but the tables labeled "Company risk-based capital ratios" and "Medical loss ratios" in Attachment B indicate that this issuer was in the North Dakota individual market in 2009. Please provide, as required by 45 CFR § 158.321(d)(2)(iii), Time Insurance Company's estimated MLR for the individual market business in North Dakota, as determined in accordance with 45 CFR § 158.221, for both 2009 and 2010. Please also provide any assumptions used in arriving at these estimates.**

The estimated PPACA MLR for the individual market is 79.2% in 2009 and 65.0% in 2010.

Also: Based on the John Alden membership below 1,000 life years, North Dakota was not credible in 2009 and 2010 for the MLR calculations and no rebates would have been paid out.

- 10. Attachment B to the application designates Time Insurance Company's estimated rebate for the individual market business in North Dakota for both 2009 and 2010 as "n/a." Please provide, as required by 45 CFR §158.321(d)(2)(v), Time Insurance Company's estimated rebate for the individual market business in North Dakota, as determined in accordance with 45 CFR §§ 158.221 and 158.240, for each of these years.**

The estimated PPACA rebate for the individual market is \$73,897 in 2009 and \$1,386,493 in 2010.

- 11. The table labeled "Profitability" in Attachment B of the application appears to provide data on net underwriting margins for the individual market business and consolidated business of six insurers in the North Dakota individual market.**

- i. Please confirm that to calculate net underwriting profit for each company in the individual market, one would multiply each issuer's underwriting profit margin for the individual business by the issuer's total earned premium figure provided in Attachment A. As required by 45 CFR § 158.321(d)(2)(vi), please also provide the net underwriting profit for each issuers' consolidated business in North Dakota, which cannot be calculated based on the information already provided.**

Blue Cross Blue Shield of ND

	All business	Individual business	All other business
2009 Underwriting gain loss)	\$8,628,000	(\$14,611,000)	\$23,239,000
2009 Underwriting margin	0.6%	(16.8%)	1.8%

John Alden Life Insurance Company

Both net underwriting profit and profit margin were provided for Individual Market and Consolidated business (Attachment B). The net underwriting profit is calculated as Earned Premium less Incurred Claims less Expenses.

Time Insurance Company

Both net underwriting profit and profit margin were provided in the attached forms for Individual Market and Consolidated business (Attachment B). The net underwriting profit is calculated as Earned Premium less Incurred Claims less Expenses.

World Insurance Company

This is correct.

Below are consolidated numbers for 2009. Note that World does not track profit margins by state. To get the numbers below, I allocated all individual medical income statement components to ND based on earned premiums except for the loss ratio, where I used the actual ND loss ratio.

2009 Net Underwriting Profit - Consolidated Business = (\$31,014), Net Underwriting Profit Margin

2009 Net Underwriting Profit Margin - Consolidated Business = -6.9%

Note that based on the segment income statements that were in place at American Enterprise prior to 2009, it is very difficult to get 2007 and 2008 numbers, even on an allocated basis. I am hopeful that the 2009 profit information will be sufficient for HHS, since they inquired about 2009 in the item below.

American Republic Ins Co

This is correct.

Below are consolidated numbers for 2009. Note that American Republic does not track profit margins by state. To get the numbers below, I allocated all individual medical income statement components to ND based on earned premiums except for the loss ratio, where I used the actual ND loss ratio.

2009 Net Underwriting Profit - Consolidated Business = (\$788,431)

2009 Net Underwriting Profit Margin - Consolidated Business = -42.3%

Note that based on the segment income statements that were in place at American Enterprise prior to 2009, it is very difficult to get 2007 and 2008 numbers, even on an allocated basis. I am hopeful that the 2009 profit information will be sufficient for the HHS.

- ii. **A single underwriting profit margin figure is provided in each applicable year for Medica Insurance Company and Blue Cross Blue Shield of North Dakota. Please clarify whether these figures are for the individual market business or the consolidated business of these issuers, as required by 45 CFR § 158.321(d)(2)(vii). As also required by 45 CFR § 158.321(d)(2)(vii), please provide the net underwriting profit for each issuer in both the individual market business and consolidated business in North Dakota.**

Blue Cross Blue Shield of ND

The profit margins provided on the original form for 2007-2009 include all BCBSND business. See above for the underwriting profit (loss) by segment.

Medica Insurance Company

- (-0.5%) was actual for 2009 Individual and 2009 was the first year in ND.
- Consolidated Corporate was (2007 = na), (2008 = -6.8%), and (2009 = -18.4%)
- Net UW profit margin is a percent of earned premium for MIC.

- iii. **World Insurance Company's 2009 underwriting profit margin in the individual market is marked as "n/a." As required by 45 CFR § 158.321(d)(2)(vii), please either provide World Insurance Company's net underwriting profit or clarify that World Insurance Company did not generate an underwriting profit in its individual market business in 2009.**

Below are the World Insurance Company numbers for 2009. These are the same as the consolidated numbers above as we only have individual medical business in ND. Note that World does not track profit margins by state. To get the numbers below, I allocated all income statement components to ND based on earned premiums except for the loss ratio, where I used the actual ND loss ratio.

2009 Net Underwriting Profit - Consolidated Business = (\$31,014), Net Underwriting Profit Margin

2009 Net Underwriting Profit Margin - Consolidated Business = -6.9%

12. **On pages 2 and 3 of the application, in response to 45 CFR § 158.321(b), which requires a description of the State's market withdrawal requirements, the NDID does not specify that issuers must submit an application for withdrawal or that issuers must have active policies insured or assumed by another issuer. However, guidelines issued by the NDID, which can be found at <http://www.nd.gov/ndins/uploads/resources/465/guidelines-for-voluntary-withdrawals.pdf>, appear to contain these and other State market withdrawal**

requirements that, if application, should be described in the NDID's application. Please explain the applicability, if any, of the requirements in the NDID Guidelines to the North Dakota health insurance market.

The document "Guidelines for Voluntary Withdrawals" would only apply if a company voluntarily withdraws from writing all lines of business in N.D. This has occurred very rarely in the past. Withdrawal from the individual health insurance market in ND is addressed under N.D.C.C. § 26.1-36.4-05(1)(f).

BlueCross BlueShield of North Dakota

An independent licensee of the
Blue Cross & Blue Shield Association



4510 13th Avenue South
Fargo, North Dakota 58121

Attachment 1

April 2011

Commissioner Adam Hamm
North Dakota Department of Insurance
State Capitol, 5th Floor
600 E. Boulevard Ave.
Bismarck, ND 58505-0320

Dear Commissioner Hamm:

We are writing to you as the Board of Noridian Mutual Insurance Company (NMIC), a not-for-profit, member-owned company. As you know, we do business in North Dakota as Blue Cross Blue Shield of North Dakota. We are a multi-line health insurer and health benefits administration organization that provides administrative services in 17 states for the Medicare and Medicaid programs, other Blue Plans and other employers. We are proud to be a North Dakota headquartered company employing 2,032 people.

We also appreciate the varied opportunities to work closely with your office. Through current and ongoing collaborations we will be able to more directly address the greatest concern residents of North Dakota face—the rising cost of health care.

With this topic in mind, and to facilitate this dialogue, we invite you to participate with us at our Board meeting on Friday, April 29, 2011.

At this meeting, we hope to discuss issues of serious concern that directly impact Blue Cross Blue Shield of North Dakota members, including:

- *Concerns that medical loss ratios are considered differently in rate reviews for BCBSND compared to other carriers. This concern is highlighted in your recent request for a waiver of medical loss ratio requirements under PPACA.*
- *The financial uncertainty related to our individual products, and the negative impact inadequate premium has in our attempts to reach agreements with Accountable Care Organizations.*



These are enormous issues and concerns that will impact health care services in North Dakota for decades to come. As a board, we have a fiduciary responsibility to balance the short and long-term fiscal viability, financial safety and soundness of NMIC, and the corresponding impact on our ability to pay our members' claims.

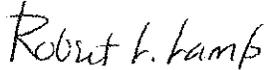
These are the issues we want to discuss with you at our Board meeting in April, as NMIC and DOI work together to improve the quality of life and health—not only for the 460,299 members of Blue Cross Blue Shield of North Dakota—but for all residents of the state.

We continue to welcome your comments and suggestions about additional actions that we can take to assure our members access to affordable, high quality health insurance and access to affordable, high quality health care.

The enclosed summary outlines our concerns in detail and includes requested actions from your office.

Thank you again for your consideration. We look forward to your early response.

Sincerely,



Chairman of the Board and on behalf of all Directors
Robert Lamp
Robert L. Lamp & Associates, Fargo

Jodi Atkinson
St. Andrew's Health Center and Clinic, Bottineau

Roger Kenner
Kenner Seed and Simmental Ranch, Leeds

Laura Carley
Industrial Builders, West Fargo

Dale Klein, M.D.
Medcenter One, Mandan

Lynette Dickson
Center for Rural Health,
University of North Dakota, Grand Forks

Ann McConn
Alerus Financial, Fargo

Dennis Elbert, Ph.D.
University of North Dakota, Grand Forks

Gary Miller
St. Alexius Medical Center, Bismarck

Richard Espeland
Consultant, Bismarck

Lynn Paulson
State Bank & Trust, Fargo

Greg Glasner, M.D.
Essentia Health, Fargo

Peter Zimmerman
Constant Angel, LLC, Minot

This summary outlines concerns regarding what appears to be unequal regulation by the North Dakota Department of Insurance that disadvantages the members of the state's largest domestic health insurance company.

Over the last several years, the relationship between Noridian Mutual Insurance Company and the Department of Insurance has been difficult at times. To recap, in 2009, the DOI issued a report that was very critical of both management and the Board of NMIC. The Board responded by improving governance of the corporation, including:

- A change in top leadership
- A complete review of executive and Board compensation against North Dakota standards
- Revised the election process for the Board
- Revised Board training and governance processes
- Responses to each of the audit findings in a manner acceptable to the DOI
- Restricted company meetings to North Dakota
- Eliminating marketing award trips
- Revised corporate travel and meeting policies
- Revised our charitable donations policy

NMIC has also adopted a new strategic plan for the BCBSND line of business that puts a greater emphasis on member needs for affordability in our premiums, stewardship of administrative costs and excellence in service. As part of the plan, we have announced a collaboration with leading health delivery organizations to reduce the rate of health care inflation over the next three years.

Commitment to NMIC Members

This commitment is demonstrated by results. NMIC health insurance premiums are among the lowest in the country. Milliman has confirmed that our payment rates to health care providers are 19 percent lower than payment rates by health plans in 7 surrounding states. Similarly, premiums at NMIC are also 19 percent lower. Our administrative costs are also among the lowest in the country and we return more than 91 cents of every premium dollar to our members as medical benefits. The underwriting margin has averaged less than 1 percent over the last 10 years. Our reserves per member are also among the lowest in the country. The level of service and customer satisfaction at NMIC are very high compared to national benchmarks.

However, recent events have raised concerns about equal application of the law for all health insurers doing business in North Dakota. Two events of particular concern are recent discussions regarding an application for a premium increase in the NMIC individual lines of business and the DOI recent request to the Secretary of Health and Human Services for a waiver on the Medical Loss Ratio (MLR) requirements of the PPACA. These two concerns will have significant short-term and long-term impacts on the members of NMIC.

Premium Rates for Individual Products

As you know, in 2008, the Department rejected an application for an increase in premiums for individually purchased products. NMIC appealed and an administrative law judge supported the NMIC position on appeal in March 2009. Due to the controversy that resulted in change of leadership, NMIC withdrew the application for an increase. In 2010, CEO Paul von Ebers spoke to you on several occasions to discuss a rate filing for these individual products. In those discussions, you requested that NMIC consider a multi-year catch up period to avoid a rate shock for our individual policy holders. NMIC agreed to a three-year catch up period, using rate increases in May 2010, May 2011 and May 2012 to get back to financially adequate rates.

Although our actuaries believed that we needed a 26.5 percent increase in order to get to adequate rates, we requested an increase of 13.1 percent in compliance with a three-year catch up plan. Your department approved 12.2 percent. This year, NMIC requested various increases for different members affected differently by PPACA, but for the largest group of members, our actuaries calculated that an increase of 23.7 percent was necessary. However, we asked for 16.7 percent, again in compliance with the three-year agreement. The Department responded with a proposal to approve an 11.4 percent increase for this largest block.

Discussions since your initial rate notification on March 3, 2011, between Department and NMIC management have narrowed the gap between respective positions. As of March 18, the Department indicated a willingness to approve an increase of 14.0 percent on the bulk of individual contracts. We appreciate the openness of the discussions and the willingness of your staff to share their calculations with us. We also appreciate the Department's willingness to consider a higher increase. However, the gap between the 16.7 percent requested and the 14.0 percent proposal represents an additional loss of approximately \$2 million for this line of business: NMIC expects to lose roughly \$6 million with a 16.7 percent increase and \$8 million with a 14.0 percent increase. Since our projected underwriting gain for the entire corporation for 2011 was \$11 million (on \$1.5 billion in revenue), a \$2 million difference is very important. The only other source of operating margin is investment returns, which have been subject to wide and erratic variations in recent years.

NMIC needs to maintain roughly a 1 percent underwriting margin and an adequate investment return on total revenue in order to maintain its current risk adjusted reserve level. While our reserves are adequate, they are hardly excessive. Under PPACA, NMIC is required to make an unlimited promise to our members for health care benefits. We owe this to our members. To back up this unlimited promise, we currently have \$609 per member in reserves. Most health plans believe the uncertainty in health insurance markets after 2014 will involve more, rather than less risk. For example, there is a risk of adverse selection due to the elimination of medical underwriting and a weak mandate for insurance. This is no time to reduce reserves. Appropriate reserves provide financial security our 460,299 member-owners while preserving the future viability and independence of North Dakota's leading domestic health insurer.

NMIC has had a loss ratio above 100 percent for our individual business for three years now. During this period of time, we have lost about \$23 million on this block of business. Since our underwriting margins and reserves are already low by industry standards, this ongoing loss must be made up in order to maintain the financial stability of BCBSND. This indirect subsidization of the individual business by other lines of business places a hardship on our employer customers, members of employer groups, and our Medicare Supplement customers. Most Medicare Supplement customers

pay their entire premium; many employers contribute part of the single premium and the entire difference between single and two person or family coverage is born by the employee. It is inequitable for these classes of members to support BCBSND's financial strength while other members continually draw down the company's financial reserves.

Today, North Dakota individual customers are paying approximately 15-20 percent of their pre-tax income for our product, even though NMIC rates are near the lowest in the nation. We share your concern for the affordability of health insurance for individual and group purchasers. That is why our strategic plan commits us to reduce the rate of inflation in health care year over year. Unfortunately, artificially depressing rates for individual purchasers does not reduce the real cost of health care. In the short run it merely shifts the costs from individual purchasers to employers and their employees. In the long run, inadequate rates in the individual market will create negative effects for all consumers in North Dakota, including members of NMIC.

Impact on Ability to Collaborate

The uncertainty about adequate premium rates is undermining the ability of BCBSND to reach agreements with Accountable Care Organizations (ACO) to reduce the cost of health care. Several major delivery systems in North Dakota have expressed a willingness to enter into total cost of care contracts over an extended period of time. These ACO contracts would create a collaborative relationship between BCBSND and health systems to work together to bring costs down through improving quality and improving best practices. These ACO agreements can also serve as a vehicle to encourage our members to seek care from North Dakota delivery systems, rather than leaving the state for care. Moving this care back to North Dakota would reduce costs, support a high quality delivery system and better serve our members. The Board of Directors and BCBSND management have a fiduciary responsibility to the company. We cannot enter into long-term contracts that fix our payment obligations when our revenue is uncertain.

If BCBSND cannot enter into collaborative agreements with health systems due to financial uncertainty and we cannot obtain adequate rates for individual products, we will have to consider alternatives that could have harmful effects on all of our individual and group customers, and on the quality and accessibility of health care in the entire state.

The first alternative is to substantially cut payment rates to providers. As previously noted, BCBSND pays hospitals and doctors at rates 19 percent below the rates paid by health plans in the surrounding states. Yet, we pay hospitals and doctors 65 percent more than Medicare for the same services. Hospitals and doctors lose money on Medicare and Medicaid and make money on Blue Cross Blue Shield. Across all payers, providers vary between very small positive and negative margins. Due to BCBSND's market share, Blue Cross Blue Shield accounts for essentially all of any positive margins that providers are able to achieve. A substantial cut in the payment rates will cause financial losses in most, if not all, hospitals and will cause physicians to leave the state. It is not an exaggeration to say that a substantial portion of health care capacity in North Dakota exists only because of current payment levels made by BCBSND. It is not unreasonable to assume that significant payment cuts from BCBSND will materially reduce the quality and access to care by all North Dakotans, not just our members. North Dakota providers are already recognized as providing low cost and high quality health care. Arbitrary payment cuts are not an answer to the problem of increasing health premiums.

We also cannot assume that all providers would accept such payment cuts. In fact, BCBSND would have to assume that some providers would refuse a contract with lower payment rates. All of our members would then suffer from reduced access to care or higher out-of-pocket costs. We prefer to use the collaborative approach to controlling health care costs while preserving quality health care, but if we find no alternative, we will attempt to cut provider payment rates in order to preserve the financial stability of BCBSND, and we will need to make our decisions regarding health system contracts by the third quarter of 2011 in order to implement either ACO contracts or payment cuts by January 1, 2012.

The second alternative would be to reconsider BCBSND's participation in the individual market itself. It is widely believed by experts within the health insurance industry and major consulting firms that a significant number of employers are likely to drop their group health insurance and send their employees to the new insurance exchanges. If this happens, it will increase the importance of the individual market and the financial implications for premium shortfalls. Further, the potential for adverse selection is likely to increase the risk of the individual market. Yet health plans are not required by federal or state law to participate in both the individual and group markets. If BCBSND loses money in a risky, large individual market we will be forced to raise our group prices, causing us to be non-competitive with health plans that offer only group policies. At some point, BCBSND may be forced to choose between exiting the individual market and going out of business.

We do not anticipate making such a harsh decision about our participation in the individual market in the near term, but it is a distinct, long-term possibility. At this time, we cannot assume, and we ask you to not assume, that BCBSND will participate in the insurance exchange for individuals in 2014. To ensure our viability, we will have to make that decision based on the structure of the exchange and the adequacy of our approved rates as we get closer to that time.

MLR Waiver Request

In the context of NMIC's ongoing losses in the individual market, the DOI's request for a waiver of medical loss ratio requirements under PPACA is particularly troubling. We are aware that the Department of Insurance has approved double-digit rate increases for out-of-state carriers who have medical loss ratios in the range of 50-70 percent over the last two years. We at NMIC believe that some of these carriers have health risk based capital (HRBC) ratios that are higher than our HRBC. We also are aware that the Department has allowed risk charges to be included in many of these rates, while risk charges are typically removed from BCBSND rate calculations.

As the largest domestic health insurance company in North Dakota, NMIC is proud of our 70-year history of adhering to not-for-profit principles. We are proud of our track record of low premiums, low administrative costs and low margins. We are proud to be a company headquartered in North Dakota that employs 2,032 people to do this important work. When NMIC is required to maintain a loss ratio over 100 percent, we cannot understand the position of the Department to allow out-of-state carriers to maintain low loss ratios, high administrative costs and high profit margins.

One of the goals of the Department of Insurance has been to promote a free, competitive and well regulated market for health insurance in North Dakota. This is one of the goals of PPACA as well. We support this goal. However, a free, open and competitive market cannot be maintained if the regulatory structure favors some companies and discourages others. We do not believe that NMIC has been provided with a level playing field in the current regulatory environment. As a North Dakota employer and a long time valuable contributor to the economic life of this state, we believe that NMIC deserves equal treatment.

To remedy our concerns, we respectfully request the following actions:

- We would appreciate a statement from you to the public, acknowledging our current loss position as it relates to individual health products, the appropriateness of the increase, and the actions taken by BCBSND to lower our administrative and medical costs.
- We request that you base next year's increase entirely on solid actuarial principles and actuarial estimates of what it will take to bring our individual products to rate adequacy.
- We request that the same principles and methodologies on our rate requests as are applied to any other carrier in similar circumstances.
- We ask that you consider withdrawing your request for a waiver on loss ratio requirements under PPACA.
- We request that you work with us and other health plans, employers, consumers and providers to identify additional ways to control health care costs while maintaining quality.

In Summary

NMIC sits at a crossroad, with choices to make that will have long-term impacts on current members as well as potential members. These decisions can best be made working in unison with the DOI. Consistent regulatory enforcement and adequate rates for individually purchased products will go a long way to assuring our members that we are jointly working on effecting change that will provide the best possible health care for the hundreds of thousands of Noridian Mutual Insurance Company members within North Dakota.

**NORTH DAKOTA
BASIC INDIVIDUAL POLICY**

Attachment 2a

AGREEMENT

With respect to each Insured Person, We will pay the insurance benefits provided in this policy. Payment is subject to the conditions, limitations and exclusions of this policy.

GUARANTEED CONTINUABLE

This policy may be renewed at the option of the insured unless the insurer elects to terminate coverage as specified in the termination of insurance provision. The policy is renewed by paying the applicable renewal premium when due or within the grace period.

RENEWAL PREMIUM

We may change the premium rates for this policy. We will give You at least 31 days notice of any change in Your renewal premium.

CHOICE OF LAW

This policy is governed by the laws of North Dakota. Any provision of this contract in conflict with North Dakota law is changed to comply with state law.

ENTIRE CONTRACT

The sections set forth on the following pages are part of this policy and take effect on the Effective Date listed on the [Schedule of Benefits] page. This policy and the attached application are the entire contract between You and Us. Oral statements made by You, by an Insured Person, or by Our agent are not part of this policy. Only Our president or vice president may make changes for Us. Such changes must be in writing and attached to this policy. All statements made for the purpose of obtaining coverage are considered representations and not warranties. No statement will be used unless a signed, written copy of the statement has been furnished to the policy holder, Insured Person, or beneficiary, as appropriate.

PRE-EXISTING CONDITION LIMITATIONS

Subject to qualifying previous coverage, this policy does not cover charges incurred by an Insured Person during the first 12 months after his or her coverage becomes effective, if those charges are incurred because of a pre-existing condition.

RIGHT TO EXAMINE

Please read Your policy carefully. Within ten (10) days of its receipt You may return the policy if not satisfied. Send the policy directly to Us. Coverage will be void as of the effective date, and We will return the premium You paid for the coverage.

President

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DEFINITIONS
as Used in this policy

Calendar Year is a period of one year which starts at 12:00 a.m. on January 1 and ends on December 31 at 11:59 p.m.

Case Management means a method of review whereby an Insured Person's catastrophic or chronic health problem is evaluated and a plan of care is developed and implemented. This plan of care will be designed to meet the specific needs of the Insured Person.

Child means an insured's natural child, legally adopted child, child legally placed with an insured for adoption or a stepchild who is both supported by and dependent upon the insured and permanently residing in the insured's household. Child also includes a child for whom the insured has been ordered by a court to provide health insurance.

Coinsurance is a percentage of the cost of a health care service, paid by Us under a health insurance plan, as stated in the schedule of benefits.

Complications of Pregnancy means conditions requiring hospital confinement that are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy. It includes but is not limited to: acute nephritis, nephrosis, cardiac decompensation, missed abortion, an emergency or non-elective caesarean section, termination of an ectopic pregnancy, or spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Copayment is a specified charge that must be paid each time care is received of a particular type or in a designated setting. The instances in which a copayment will be required are specified in the schedule of benefits. Copayments must be paid before any other payment will be made under the policy. Copayments will not count toward the out-of-pocket maximum required under Your policy.

Dependent means a spouse; an unmarried child under the age of twenty-two (22); an unmarried child who is a full-time student under the age of twenty-six (26) and who is financially dependent upon the insured; a child of an unmarried child who is financially dependent upon the insured; and an unmarried child of any age who is medically certified as disabled and dependent on the insured.

Experimental Treatment means the treatment is not generally accepted by the medical community; or the facility is not recognized as being able to properly perform the treatment; or the treatment is not considered to be effective for the injury or sickness.

Health Benefit Plan means any hospital or medical expense-incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, specified disease, individual

hospital indemnity, credit, dental-only, vision-only, Medicare Supplement, long term care or disability income insurance, worker's compensation or similar insurance or automobile medical-payment insurance.

Insured Person means an Insured or Dependent who is eligible for coverage, who has met the application requirements of the policy, and for whom all due premiums have been paid.

Medical Emergency means the sudden and unexpected onset of a condition which has symptoms that require immediate medical care to prevent death or serious impairment of the Insured Person's health; or that pose a serious threat to the patient or to others.

Medically Necessary means the shortest, least expensive or least intense level of treatment, care or service rendered, or supply provided, as determined by Us, to the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the Insured Person's medical condition, is known to be safe and effective by most physicians who are licensed to treat the condition at the time the service is rendered and is not provided primarily for the convenience of the Insured Person or physician.

Out-of-Pocket Expense is the medical expense that an Insured Person must pay, which includes Coinsurance but not Copayments, as listed on the schedule of benefits.

Partial Hospitalization means continuous treatment for at least 3 hours, but not more than 12 hours, in any twenty-four hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

Pre-Existing Condition means a condition for which diagnosis or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage. This Health Benefit Plan shall not deny, exclude or limit benefits for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a pre-existing condition.

A Pre-existing Condition waiting period will be reduced for the period of time an individual was previously covered by Qualifying Previous Coverage, provided that the Qualifying Previous Coverage was continuous to a date not greater than 90 days prior to an Insured Person's effective date under this policy.

Qualifying Previous/Qualifying Existing Coverage means benefits or coverage provided under:

- (1) Medicare, Medicaid, Civilian Health and Medical Program for Uniformed Services, Indian Health Services Program, or any other similar publicly sponsored program.
- (2) A health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

- (3) An individual health insurance policy, including coverage issued by a health maintenance organization, nonprofit health service corporation and fraternal benefit society that provides benefits similar to and exceeding the benefits provided under the basic health plan, provided that the policy has been in effect for a period of at least one year.

Reasonable and Customary means charges not in excess of like charges made by at least a majority of providers in the locality where the service or supply was furnished, taking into consideration the nature and severity of the injury or sickness involved.

We, Our, Us means the insurance company shown on the face page.

Well Child Care includes but is not limited to: a medical history, physical exam, developmental assessment, anticipatory guidance, appropriate immunizations and lab tests.

You, Your means the policy holder.

CONDITIONS FOR INSURANCE

EVIDENCE OF INSURABILITY

We require an application and evidence of insurability satisfactory to Us for all persons to be insured under this policy. We have the right to accept or decline coverage based on the information in the application and evidence of insurability forms.

EFFECTIVE DATE

The effective date of Your [and Your Eligible Dependents] coverage is stated on the [Schedule of Benefits page].

DEPENDENT COVERAGE (If Available)

Each Dependent is eligible to enroll if that person satisfies the definition of Dependent. We require You to submit evidence of insurability for each Dependent. We have the right to accept or decline the Dependent based on the information in the application and evidence of insurability.

If You acquire Dependents at a later date and want them covered, You must enroll each new Dependent within 31 days from the date: You marry, for spouse and stepchildren; a child is born to You; a child is placed in Your home for purpose of adoption; or You are legally responsible for a foster child. You must pay any required increase in premium, if applicable.

Important: Newborn and Adopted Coverage. We will provide medical insurance for a newborn child for 31 days from the date of birth or for an adopted child for 31 days from the date of placement. You must apply for coverage within 31 days; otherwise, the child's insurance ends on the 31st day.

BENEFIT CHANGE

Any change in benefits or family status will become effective on the first of the month coinciding with or next following the date of change in status.

TERMINATION OF INSURANCE

Insurance terminates on the earliest of these events:

- (1) The date the Insured Person cancels coverage under this policy.
- (2) The end of the period for which required premiums are due but not paid; or
- (3) The date We determine that misrepresentation or fraud in the application or claims presentation has occurred.

For a Dependent, insurance terminates on the date that person no longer satisfies the definition of Dependent. The Insured Person must notify Us as soon as a Dependent ceases to be eligible. This allows Us to promptly make any needed change in coverage and/or premium.

BENEFITS**INSURANCE PROVISION**

If an Insured Person incurs Reasonable and Customary expense for covered charges because of an injury or sickness, We will pay a percentage of the expense after the Copayment, if any, is satisfied. The applicable Coinsurance percentage, Copayments, Out-Of-Pocket limitation and benefit maximum limitations for Insured Persons are shown in the Schedule of Benefits.

COVERED CHARGES

Covered charges must be incurred due to injury or illness while a person is insured under this policy. No benefits are payable for charges incurred before insurance begins or after insurance ends.

A charge will be considered incurred on the date the service or treatment is performed or of the purchase giving rise to the charge. The amount payable for covered charges will be determined by the Schedule of Benefits in effect at the time each charge is incurred.

Covered charges include only the charges described below that are: (a) medically necessary; (b) recommended by a physician; (c) incurred by an Insured Person, and (d) are not otherwise excluded from coverage under this policy.

Inpatient Hospital Services:

Includes charges for room, board, and intensive care at the semi-private room rate, subject to the Copayment and Coinsurance listed in the schedule. Covered charges also include medical services of a physician, nursing services, and therapeutic services as prescribed by

a physician. Emergency room charges are covered for injuries, subject to the Copayment and Coinsurance listed in the schedule. Emergency room charges are covered for illnesses only when the Insured Person is admitted to the hospital, subject to the Copayment and Coinsurance listed in the schedule.

Coverage is also provided for medically appropriate miscellaneous services and supplies, including x-rays; laboratory and diagnostic tests; radiation or chemotherapy; oxygen, other gases and their administration; and other ancillary services.

Inpatient, Outpatient and Special Surgical Services:

Includes charges for surgeon services, assistant surgeon services and anesthesiology services. Post-operative care is included in the amount payable for the surgery. This benefit also covers a second opinion by an appropriate specialist.

Special surgical services are subject to the maximum benefits listed in the schedule and are limited to:

- (1) Reconstructive surgery for congenital disorders for Covered Persons under age 18, subject to the maximum benefit listed in the schedule.
- (2) Reconstructive surgery for the correction/restoration of the body due to accidental injury, disease, or surgery covered by the plan, subject to the maximum benefit listed in the schedule.
- (3) Organ transplant surgery, including all services related to the procedure, subject to the maximum benefit listed in the schedule.

Outpatient Hospital and Medical Services covers charges for:

- (1) Diagnostic laboratory and X-ray services.
- (2) Radiation therapy and chemotherapy.
- (3) Visual training for the treatment of amblyopia by an Ophthalmologist or Optometrist is covered for children under age 10, subject to the limits on the schedule.
- (4) Well child care services are covered according to the following schedule: five visits for Insured Persons from birth through 12 months of age; three visits for Insured Persons from 13 months through 24 months of age; one visit per Benefit Period for Covered Persons from 25 months through 72 months of age.

Maternity Services:

Covers pre- and post-natal care, inpatient hospital and medical care, including certified nurse mid-wife care. Complications of pregnancy are covered as any other illness.

Psychiatric and Substance Abuse Services:

Inpatient psychiatric care covers charges for crisis intervention services only. Inpatient substance abuse care covers charges for detoxification only, limited to 3 lifetime treatments. Coverage is available for a maximum of 40 lifetime visits for any combination of partial hospitalization and outpatient care.

Ambulance:

Charges are covered for travel to a hospital where necessary emergency

care or emergency treatment is rendered.

Skilled Nursing Facility Services:

Are covered for room, board and general nursing care on a case management basis.

Intensive Home Health Care:

Is covered on a case management basis for services prescribed by a physician and performed by a licensed home health care agency, if it would normally be covered when performed in a hospital by hospital personnel.

Hospice Care:

Is covered on a case management basis in lieu of all other care to treat a terminal sickness. Terminal sickness means You have less than six months to live.

EXCLUSIONS AND LIMITATIONS

Covered expenses will not include, and no benefits will be paid for, any charges which are incurred:

- (1) For abortions.
- (2) For acupuncture and accupressure.
- (3) For autopsies.
- (4) For annual physicals.
- (5) For autism, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation.
- (6) For biofeedback.
- (7) For charges incurred prior to the Insured Person's effective date, or after date of termination of coverage.
- (8) For charges in excess of Reasonable and Customary charges.
- (9) For complications or side effects of excluded services, procedures or treatments.
- (10) For cosmetic surgery.
- (11) For contraceptives, and prescription/nonprescription medication.
- (12) For counseling for gambling addiction.
- (13) For custodial care.
- (14) For dental care.
- (15) For dietary control or surgical treatment of obesity.
- (16) For education.
- (17) For electronic speech aids, robotization prosthetics, myoelectronic prosthetics, customized cutaneous dermal protective covers, endolite prosthetic systems or artificial organs.
- (18) For exercise programs, health and athletic club membership or use.
- (19) For experimental, investigatory and research procedures.
- (20) For eyeglasses, contact lenses or hearing aids.
- (21) For footcare for weak, strained, unstable or unbalanced feet or ankles; bony protuberances of the forefoot or toes.
- (22) For hypnotism.

- (23) For infertility testing and treatment.
- (24) For injury or sickness caused by war or occurring while in military service.
- (25) For inpatient admissions for diagnostic services or physical therapy.
- (26) For loss in which a contributing cause was the member's commission or attempted commission of a felony or participation in a riot.
- (27) For marriage and family therapy.
- (28) When no fault insurance coverage is primary.
- (29) For orthomolecular therapy.
- (30) For orthotic devices, including orthopedic shoes, and durable medical equipment required for leisure or recreational activity or to allow the member to participate in sports activity.
- (31) For outpatient consultations.
- (32) For personal hygiene and convenience items.
- (33) For private rooms.
- (34) For radial keratotomy.
- (35) For sex change operations.
- (36) For sexual dysfunction.
- (37) For self inflicted injury.
- (38) For services for which benefits are provided or received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- (39) For services not medically necessary.
- (40) For services performed by family members.
- (41) For services not customarily charged for when insurance is not in force.
- (42) For services performed by non-licensed, non-certified professionals, or for services performed outside the scope of practice of licensed, certified professionals.
- (43) For standby services.
- (44) For sterilization reversal.
- (45) For thermography.
- (46) For telephone consultations, or failure to keep appointments.
- (47) For testicular prosthesis.
- (48) For travel expenses.
- (49) For unnecessary weekend admissions.
- (50) For vocational rehabilitative services.
- (51) For benefits provided by Workers Compensation.

GENERAL PROVISIONS

PREMIUMS

The first premium is collected with the original application. Each premium thereafter must be paid on or before the date they are due. If We receive written notice that insurance will terminate prior to the due date, then no premium is due on such date.

Payments are payable directly to Us at the address shown on the billing statement. A check is not a payment until it is honored by the bank.

GRACE PERIOD

We allow a grace period of 31 days from the premium due date in which to pay each premium. Insurance will terminate at the end of the grace period if the premiums have not been paid. If a loss occurs during this grace period, any premium not paid will be deducted from any benefit then payable.

INCONTESTABILITY

After You are insured with Us for two years, We cannot contest the validity of Your insurance, except for non-payment of premium or for fraud.

RESCISSION OF INSURANCE

Subject to the incontestability provision, We reserve the right to rescind insurance on any Insured Person because of the Person's material misrepresentation or fraud. If no medical claims have been paid by Us on the date We rescind, We will return all premiums paid for the rescinded insurance. If claims have been paid, We reserve the right to subtract the amount of claims paid from the returned premiums.

NOTICE OF PROOF AND CLAIM

Written notice of loss must be sent to Us within 20 days after a claim is incurred. Notice must identify the name of the Insured Person who incurred the claim and the Person's mailing address.

When We receive notice, if necessary, We will send the claim forms for filing proof of loss within 15 days from the date Your notice was received. If these forms are not sent within 15 days, the claimant will meet the proof of loss requirement by giving Us a written statement of the nature and extent of the losses.

Written proof of loss must be given to Us within 90 days after the date of loss. No claim will be reduced or denied by Us if it was not reasonably possible for You to submit the Proof within 90 days. In any event, We must receive proof within one year after it is due unless the Insured Person is legally incapable of doing so.

PAYMENT OF CLAIMS

We will pay claims upon receipt of authorized proof of loss. We may pay benefits directly to the provider of services. After We make an authorized payment of benefits, We are discharged from paying further benefits to the extent of the payment. If You want payment made to You, You must notify Us on or before We receive Your Proof of Loss.

If any benefits are payable to the Insured Person's estate or to a person who is a minor or otherwise is not competent to give a valid release, We may pay such benefits up to an amount not exceeding [\$5,000] to a Family Member of such Person, who We deem to be equitably entitled to the benefits. Any payment We make in good faith under this provision fully discharges Us to the extent of Our Payment.

PHYSICAL EXAM AND AUTOPSY

We have the right to have You physically examined, at Our expense, pending payment of a claim. We also have the right, at Our expense, to have an autopsy performed at Your death, unless forbidden by North

Dakota law.

LEGAL ACTIONS

No lawsuit may be brought to recover a claim from Us until more than 60 days after the date written Proof of Loss is made. Such action cannot be made more than three years after the date written proof of loss is made.

MISSTATEMENT OF AGE

If Your age is misstated, We will adjust the premium amount to conform with the correct age.

SUBROGATION

The rights of the persons covered under this policy to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to Us, but only to the extent of benefit payments made under this policy. You shall promptly advise Us whenever a claim against another party is made and You agree to fully cooperate in protecting Our rights against a third party.

CLAIMS APPEAL PROCEDURE

[We will provide a written explanation of the reason We deny a claim for benefits as a whole or in part. If there is any question about the settlement or denial of a claim, an Insured Person (or an Insured Person's beneficiary in case of death), has the right to request a full and fair review of that claim.]

AGREEMENT

With respect to each Insured Person, We will pay the insurance benefits provided in this policy. Payment is subject to the conditions, limitations and exclusions of this policy.

GUARANTEED CONTINUABLE

This policy may be renewed at the option of the insured unless the insurer elects to terminate coverage as specified in the termination of insurance provision. The policy is renewed by paying the applicable renewal premium when due or within the grace period.

RENEWAL PREMIUM

We may change the premium rates for this policy. We will give You at least 31 days notice of any change in Your renewal premium.

CHOICE OF LAW

This policy is governed by the laws of North Dakota. Any provision of this contract in conflict with North Dakota law is changed to comply with state law.

ENTIRE CONTRACT

The sections set forth on the following pages are part of this policy and take effect on the Effective Date listed on the [Schedule of Benefits] page. This policy and the attached application are the entire contract between You and Us. Oral statements made by You, by an Insured Person, or by Our agent are not part of this policy. Only Our president or vice president may make changes for Us. Such changes must be in writing and attached to this policy. All statements made for the purpose of obtaining coverage are considered representations and not warranties. No statement will be used unless a signed, written copy of the statement has been furnished to the policy holder, Insured Person, or beneficiary, as appropriate.

PRE-EXISTING CONDITION LIMITATIONS

Subject to qualifying previous coverage, this policy does not cover charges incurred by an Insured Person during the first 12 months after his or her coverage becomes effective, if those charges are incurred because of a pre-existing condition.

RIGHT TO EXAMINE

Please read Your policy carefully. Within ten (10) days of its receipt You may return the policy if not satisfied. Send the policy directly to Us. Coverage will be void as of the effective date, and We will return the premium You paid for the coverage.

President

**STANDARD PLAN
SCHEDULE OF BENEFITS**

LIFETIME BENEFIT MAXIMUMS PER Insured Person

For all benefits in the aggregate	\$1,000,000
Hospice	5,000
Smoking cessation incentive	150
TMJ or CMJ treatment - Surgical	10,000
- Nonsurgical	2,500
Transplant Services	100,000

CALENDAR YEAR DEDUCTIBLE

Single	\$250
Family Maximum	500

COINSURANCE PERCENTAGE 80%

COPAYMENT AMOUNTS

Emergency room, per treatment	\$50
Office visit	10
Prenatal maternity care, per visit	5*
Prescription drugs, per prescription	10
Well child care, per visit	2*

The Deductible does not apply to services for which a Copayment is applied.

*100% coinsurance thereafter.

OUT-OF-POCKET-MAXIMUMS

Per Insured Person	\$2,000
Per Covered Family	4,000

Copayment amounts do not accumulate toward the out-of-pocket maximum.

SPECIAL FEATURES AND LIMITATIONS

For each person covered under the policy We will not pay benefits for services rendered either more often than stated below, or in an amount greater than the limit shown below:

Accidental dental injury, per occurrence, per person \$5,000

Adult Immunizations, per year, per person:

- Tetnus-diphtheria toxoid Every 10 years
- Pneumococcal vaccine Only when physician certifies as high risk
- Influenza vaccine Only when physician certifies as high risk

Ambulance, per occurrence \$2,000

Intraocular lens prosthesis, per lens, per occurrence \$120

Medical supplies and equipment, per year, per person \$5,000

Nutrition care, per year, per person \$200

Physical, occupational, and speech therapy, cardiac
rehabilitation and respiratory care, combined, per
year, per person \$1,500

Preventive Services, per year, per person:

Urinalysis Every 5 years

Total serum cholesterol testing Every 5 years

Pap smear Every 3 years

Mammogram 1 service age 35-39
1 service per 2 years age 40-49
(or more frequently if physician ordered)
1 service annually age 50 and up

Psychiatric and Substance Abuse Services, per year, per person:

Inpatient services 60 days

Partial hospitalization 120 days

Outpatient psychiatric services 30 hours*

Outpatient substance abuse services 20 visits*

* First 5 hours/visits paid at 100%, thereafter paid at 80%

Visual training for amblyopia, per lifetime, per person 16 visits

Revised 11/01/95

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DEFINITIONS
CONDITIONS FOR INSURANCE COVERAGE
BENEFITS
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DEFINITIONS
as Used in this policy

Calendar Year is a period of one year which starts at 12 a.m. on January 1 and ends on December 31 at 11:59 p.m.

Case Management means a method of review whereby an Insured Person's catastrophic or chronic health problem is evaluated and a plan of care is developed and implemented. This plan of care will be designed to meet the specific needs of the Insured Person.

Child means an insured's natural child, legally adopted child, child legally placed with an insured for adoption or a stepchild who is both supported by and dependent upon the insured and permanently residing in the insured's household. Child also includes a child for whom the insured has been ordered by a court to provide health insurance.

Coinsurance is a percentage of the cost of a health care service, paid by Us under a health insurance plan, as stated in the schedule of benefits.

Complications of Pregnancy means conditions requiring hospital confinement that are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy. It includes but is not limited to: acute nephritis, nephrosis, cardiac decompensation, missed abortion, an emergency or non-elective caesarean section, termination of an ectopic pregnancy, or spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Copayment is a specified charge that must be paid each time care is received of a particular type or in a designated setting. The instances in which a copayment will be required are specified in the schedule of benefits. The copayments must be paid before any other payment will be made under the policy. Copayments will not count toward any deductible required under Your policy.

Dependent means a spouse; an unmarried child under the age of twenty-two (22); an unmarried child who is a full-time student under the age of twenty-six (26) and who is financially dependent upon the insured; a child of an unmarried child who is financially dependent upon the insured; and an unmarried child of any age who is medically certified as disabled and dependent on the insured.

Experimental Treatment means the treatment is not generally accepted by the medical community; or the facility is not recognized as being able to properly perform the treatment; or the treatment is not considered to be effective for the injury or sickness.

Health Benefit Plan means any hospital or medical expense-incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, specified disease, individual

hospital indemnity, credit, dental-only, vision-only, Medicare Supplement, long term care or disability income insurance, worker's compensation or similar insurance or automobile medical-payment insurance.

Insured Person means an Insured or Dependent who is eligible for coverage, who has met the application requirements of the policy, and for whom all due premiums have been paid.

Medical Emergency means the sudden and unexpected onset of a condition which has symptoms that require immediate medical care to prevent death or serious impairment of the Insured Person's health, or that poses a serious threat to the patient or to others.

Medically Necessary means the shortest, least expensive or least intense level of treatment, care or service rendered, or supply provided, as determined by Us, to the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the Insured Person's medical condition, is known to be safe and effective by most physicians who are licensed to treat the condition at the time the service is rendered and is not provided primarily for the convenience of the Insured Person or physician.

Out-of-Pocket Expense is the medical expense that an Insured Person must pay, which includes Deductibles and Coinsurance but not Copayments, as listed on the schedule of benefits.

Partial Hospitalization means continuous treatment for at least 3 hours, but not more than 12 hours, in any twenty-four hour period and includes the medically necessary treatment services provided by licensed professionals under the supervision of a licensed physician.

Pre-Existing Condition means a condition for which diagnosis or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage. This Health Benefit Plan shall not deny, exclude or limit benefits for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a pre-existing condition.

A Pre-existing Condition waiting period will be reduced for the period of time an individual was previously covered by Qualifying Previous Coverage, provided that the Qualifying Previous Coverage was continuous to a date not greater than 90 days prior to an Insured Person's effective date under this policy.

Qualifying Previous/Qualifying Existing Coverage means benefits or coverage provided under:

- (1) Medicare, Medicaid, Civilian Health and Medical Program for Uniformed Services, Indian Health Services Program, or any other similar publicly sponsored program.
- (2) A health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

- (3) An individual health insurance policy, including coverage issued by a health maintenance organization, nonprofit health service corporation and fraternal benefit society that provides benefits similar to and exceeding the benefits provided under the basic health plan, provided that the policy has been in effect for a period of at least one year.

Reasonable and Customary means charges not in excess of like charges made by at least a majority of providers in the locality where the service or supply was furnished, taking into consideration the nature and severity of the injury or sickness involved.

We, Our, Us means the insurance company shown on the face page.

Well Child Care includes but is not limited to: a medical history, physical exam, developmental assessment, anticipatory guidance, appropriate immunizations and lab tests.

You, Your means the policy holder.

CONDITIONS FOR INSURANCE

EVIDENCE OF INSURABILITY

We require an application and evidence of insurability satisfactory to Us for all persons to be insured under this policy. We have the right to accept or decline coverage based on the information in the application and evidence of insurability forms.

EFFECTIVE DATE

The effective date of Your [and Your Dependents] coverage is stated on the [Schedule of Benefits page].

DEPENDENT COVERAGE (If available)

Each Dependent is eligible to enroll if that person satisfies the definition of Dependent. We require You to submit evidence of insurability for each Dependent. We have the right to accept or decline the Dependent based on the information in the application and evidence of insurability.

If You acquire Dependents at a later date and want them covered, You must enroll each new Dependent within 31 days from the date: You marry, for spouse and stepchildren; a child is born to You; a child is placed in Your home for purpose of adoption; or You are legally responsible for a foster child. You must pay any required increase in premium, if applicable.

Important: Newborn and Adopted Coverage. We will provide medical insurance for a newborn child for 31 days from the date of birth or for an adopted child for 31 days from the date of placement. You must apply for coverage within 31 days; otherwise, the child's insurance ends on the 31st day.

BENEFIT CHANGE

Any change in benefits or family status will become effective on the first of the month coinciding with or next following the date of change in status.

TERMINATION OF INSURANCE

Insurance terminates on the earliest of these events:

- (1) The date the Insured Person cancels coverage under this policy.
- (2) The end of the period for which required premiums are due but not paid; or
- (3) The date We determine that misrepresentation or fraud in application or claims presentation has occurred.

For a Dependent, insurance terminates on the date that person no longer satisfies the definition of Dependent. The Insured Person must notify Us as soon as a Dependent ceases to be eligible. This allows Us to promptly make any needed change in coverage and/or premium.

BENEFITS**INSURANCE PROVISION**

If an Insured Person incurs Reasonable and Customary expense for covered charges because of an injury or sickness, We will pay a percentage of the expense after the Deductible and Copayment, if any, are satisfied. The applicable Deductible, Coinsurance percentage, Copayments, Out-Of-Pocket limitation and benefit maximum limitations for Insured Persons are shown in the Schedule of Benefits.

COVERED CHARGES

Covered charges must be incurred due to injury or illness while a person is insured under this policy. No benefits are payable for charges incurred before insurance begins or after insurance ends.

A charge will be considered incurred on the date the service or treatment is performed or of the purchase giving rise to the charge. The amount payable for covered charges will be determined by the Schedule of Benefits in effect at the time each charge is incurred.

Covered charges include only the charges described below that are: (a) medically necessary; (b) recommended by a physician; (c) incurred by an Insured Person, and (d) are not otherwise excluded from coverage under this policy.

Inpatient Hospital Services:

Includes charges for room, board, and intensive care at the semi-private room rate. Covered charges also include medical services of a physician, nursing services, and therapeutic services as prescribed by a physician. Emergency room charges are covered for

injuries, subject to the Copayment and Coinsurance listed in the schedule. Emergency room charges are covered for illnesses only when the Insured Person is admitted to the hospital, subject to the Copayment and Coinsurance listed in the schedule.

Coverage is also provided for medically appropriate miscellaneous services and supplies, including x-rays; laboratory and diagnostic tests; radiation or chemotherapy; oxygen, other gases and their administration; and other ancillary services.

Inpatient, Outpatient and Special Surgical Services:

Includes charges for surgeon services, assistant surgeon services and anesthesiology services. Post-operative care is included in the amount payable for the surgery. This benefit also covers a second opinion by an appropriate specialist.

Special surgical services are limited to medically necessary reconstructive surgery, sterilization procedures, and transplant services, subject to the maximum limit listed in the schedule.

Outpatient Hospital and Medical Services covers charges for:

- (1) Adult preventive care and immunizations, as listed in the schedule.
- (2) Allergy testing and injectibles.
- (3) Diagnostic laboratory and X-ray services.
- (4) Dialysis.
- (5) Mammography services, subject to the maximum benefit listed in the schedule.
- (6) Nutrition care, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and respiratory care when prescribed by a physician, subject to the maximum benefits listed in the schedule.
- (7) Physician home and office calls are covered, as are chiropractic office calls, subject to Copayment and Coinsurance as listed in the schedule.
- (8) Radiation therapy and chemotherapy.
- (9) A smoking cessation incentive of \$150 is payable when the Covered Person is certified by a physician as smoke-free for 12 months, following completion of a physician-supervised smoking cessation program.
- (10) Surgical and non-surgical treatment of TMJ or CMJ, subject to the benefit maximum listed in the schedule.
- (11) Visual training for the treatment of amblyopia by an Ophthalmologist or Optometrist is covered for children under age 10, subject to the maximum benefit listed in the schedule.
- (12) Well child care services are covered according to the following schedule: five visits for Insured Persons from birth through 12 months of age; three visits for Insured Persons from 13 months through 24 months of age; one visit per Benefit Period for Covered Persons from 25 months through 72 months of age, subject to Copayment only as listed in the schedule.

Maternity Services:

Covers pre- and post-natal care, inpatient hospital and medical care,

including certified nurse mid-wife care. Complications of pregnancy are covered as any other illness.

Psychiatric Services:

Are covered, subject to the limits listed in the schedule. Inpatient days may be traded for additional partial hospitalization days. One hospital day is equal to 2 partial hospitalization days. No more than 46 hospital days may be traded. The first 5 hours of outpatient services are paid at 100%. Coinsurance after the first 5 visits is 80%.

Substance Abuse Services:

Are covered, subject to the limits listed in the schedule. Inpatient days may be traded for additional partial hospitalization days. One hospital day is equal to 2 partial hospitalization days. No more than 46 hospital days may be traded. The first 5 visits of outpatient services are paid at 100%. Coinsurance after the first 5 visits is 80%.

Ambulance:

Charges are covered for travel to a hospital where necessary emergency care or emergency treatment is rendered.

Skilled Nursing Facility Services:

Are covered on a case management basis for room, board and general nursing care.

Intensive Home Health Care:

Is covered on a case management basis for services prescribed by a physician and performed by a home health care agency, if it would normally be covered if performed in a hospital by hospital personnel.

Private Duty Nursing:

Is covered on a case management basis for outpatient services prescribed by a physician and performed by a Registered Nurse, if it would normally be covered when performed in a hospital by hospital personnel.

Hospice Care:

Is covered in lieu of all other care to treat a terminal sickness. Terminal sickness means You have less than six months to live. Charges are paid up to the maximum benefit listed in the schedule.

Accidental Dental Injury:

For damage done to natural teeth when charges are incurred within six months of the accident or as part of a treatment plan prescribed by a physician and begun within six months of the accident. Charges are paid up to the maximum benefit listed in the schedule.

Supplemental Services:

Covers home medical equipment, prosthetic appliances, orthotic devices, and supplies for administration of prescription medications up to the maximum benefit listed in the schedule.

Outpatient Prescription Medication:

Covers drugs and medicines which by law require written prescription by a physician and are dispensed by a licensed pharmacy up to the generic charge, subject to the Copayment and Coinsurance listed in the schedule.

EXCLUSIONS AND LIMITATIONS

Covered expenses will not include, and no benefits will be paid for, any charges which are incurred:

- (1) For abortions.
- (2) For acupuncture and accupressure.
- (3) For autopsies.
- (4) For annual physicals.
- (5) For autism, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation.
- (6) For biofeedback.
- (7) For charges incurred prior to the Insured Person's effective date, or after date of termination of coverage.
- (8) For charges in excess of Reasonable and Customary charges.
- (9) For complications or side effects of excluded services, procedures or treatments.
- (10) For cosmetic surgery.
- (11) For contraceptives and nonprescription medication.
- (12) For counseling for gambling addiction.
- (13) For custodial care.
- (14) For dental care.
- (15) For dietary control or surgical treatment of obesity.
- (16) For education.
- (17) For electronic speech aids, robotization prosthetics, myoelectronic prosthetics, customized cutaneous dermal protective covers, endolite prosthetic systems or artificial organs.
- (18) For exercise programs, health and athletic club membership or use.
- (19) For experimental, investigatory and research procedures.
- (20) For eyeglasses, contact lenses or hearing aids.
- (21) For footcare for weak, strained, unstable or unbalanced feet or ankles; bony protuberances of the forefoot or toes.
- (22) For hypnotism.
- (23) For infertility testing and treatment.
- (24) For injury or sickness caused by war or occurring while in military service.
- (25) For inpatient admissions for diagnostic services or physical therapy.
- (26) For loss in which a contributing cause was the member's commission or attempted commission of a felony or participation in a riot.
- (27) For marriage and family therapy.
- (28) When no fault insurance coverage is primary.
- (29) For orthomolecular therapy.
- (30) For orthotic devices, including orthopedic shoes, and durable medical equipment required for leisure or recreational activity or to allow the member to participate in sports activity.
- (31) For personal hygiene and convenience items.

- (32) For private rooms.
- (33) For radial keratotomy.
- (34) For sex change operations.
- (35) For sexual dysfunction.
- (36) For self inflicted injury.
- (37) For services for which benefits are provided or received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- (38) For services not medically necessary.
- (39) For services performed by family members.
- (40) For services not customarily charged for when insurance is not in force.
- (41) For services performed by non-licensed, non-certified professionals, or for services performed outside the scope of practice of licensed, certified professionals.
- (42) For standby services.
- (43) For sterilization reversal.
- (44) For thermography.
- (45) For telephone consultations, or failure to keep appointments.
- (46) For testicular prosthesis.
- (47) For travel expenses.
- (48) For unnecessary weekend admissions.
- (49) For vocational rehabilitative services.
- (50) For benefits provided by workers compensation.

GENERAL PROVISIONS

PREMIUMS

The first premium is collected with the original application. Each premium thereafter must be paid on or before the date they are due. If We receive written notice that insurance will terminate prior to the due date, then no premium is due on such date.

Payments are payable directly to Us at the address shown on the billing statement. A check is not a payment until it is honored by the bank.

GRACE PERIOD

We allow a grace period of 31 days from the premium due date in which to pay each premium. Insurance will terminate at the end of the grace period if the premiums have not been paid. If a loss occurs during this grace period, any premium not paid will be deducted from any benefit then payable.

INCONTESTABILITY

After You are insured with Us for two years, We cannot contest the validity of Your insurance, except for non-payment of premium or for fraud.

RESCISSION OF INSURANCE

Subject to the incontestability provision, We reserve the right to rescind insurance on any Insured Person because of the Person's

material misrepresentation or fraud. If no medical claims have been paid by Us on the date We rescind, We will return all premiums paid for the rescinded insurance. If claims have been paid, We reserve the right to subtract the amount of claims paid from the returned premiums.

NOTICE OF PROOF AND CLAIM

Written notice of loss must be sent to Us within 20 days after a claim is incurred. Notice must identify the name of the Insured Person who incurred the claim and the Person's mailing address.

When We receive notice, if necessary, We will send the claim forms for filing proof of loss within 15 days from the date Your notice was received. If these forms are not sent within 15 days, the claimant will meet the proof of loss requirement by giving Us a written statement of the nature and extent of the losses.

Written proof of loss must be given to Us within 90 days after the date of loss. No claim will be reduced or denied by Us if it was not reasonably possible for You to submit the Proof within 90 days. In any event, We must receive proof within one year after it is due unless the Insured Person is legally incapable of doing so.

PAYMENT OF CLAIMS

We will pay claims upon receipt of authorized proof of loss. We may pay benefits directly to the provider of services. After We make an authorized payment of benefits, We are discharged from paying further benefits to the extent of the payment. If You want payment made to You, You must notify Us on or before We receive Your Proof of Loss.

If any benefits are payable to the Insured Person's estate or to a person who is a minor or otherwise is not competent to give a valid release, We may pay such benefits up to an amount not exceeding [\$5,000] to a Family Member of such Person, who We deem to be equitably entitled to the benefits. Any payment We make in good faith under this provision fully discharges Us to the extent of Our Payment.

PHYSICAL EXAM AND AUTOPSY

We have the right to have You physically examined, at Our expense, pending payment of a claim. We also have the right, at Our expense, to have an autopsy performed at Your death, unless forbidden by North Dakota law.

LEGAL ACTIONS

No lawsuit may be brought to recover a claim from Us until more than 60 days after the date written Proof of Loss is made. Such action cannot be made more than three years after the date written proof of loss is made.

MISSTATEMENT OF AGE

If Your age is misstated, We will adjust the premium amount to conform with the correct age.

SUBROGATION

The rights of the persons covered under this policy to claim or receive compensation, damages, or other payment from the other party or parties

will be transferred to Us, but only to the extent of benefit payments made under this policy. You shall promptly advise Us whenever a claim against another party is made and You agree to fully cooperate in protecting Our rights against a third party.

CLAIMS APPEAL PROCEDURE

[We will provide a written explanation of the reason We deny a claim for benefits as a whole or in part. If there is any question about the settlement or denial of a claim, an Insured Person (or an Insured Person's beneficiary in case of death), has the right to request a full and fair review of that claim.]