

CHAND Eligibility Guidelines September 2011

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Application Requirements

Traditional	Age 65 & Over or Disabled	HIPAA	TAARA
Each section of the application must be completed fully and accompanied by premium and evidence to prove eligibility.	Each section of the application must be completed fully and accompanied by premium and evidence to prove eligibility.	Each section of the application must be completed fully and accompanied by premium and evidence to prove eligibility or document enough information to verify eligibility.	Each section of the application must be completed fully and accompanied by premium and evidence to prove eligibility.
Applicants applying due to reaching the lifetime maximum coverage amount of his/her most recent health insurance coverage must submit his/her application within 90 days of the lifetime maximum occurring and be accompanied by premium for coverage retroactive to the date that the lifetime maximum occurred.	Applicant must be eligible for and enrolled in Medicare A & B by reason of age or disability.	Applications must be submitted within 63 days of prior coverage terminating.	Applications must be submitted within 63 days of prior coverage terminating.
Applications must be submitted within 180 days of the date shown on the evidence of eligibility if applying due to rejection/refusal; restrictive rider notice; excessive rate notice; or medical condition letter.	Applications must be submitted within 180 days of the date shown on the evidence of eligibility if applying due to rejection/refusal; restrictive rider notice; excessive rate notice; or medical condition letter.	Spouse and each dependent must submit a separate application.	If an individual qualifies as a PBGC or TAA individual, HCTC will generate a HCTC Eligibility Certificate (Letter #L3779 Revised 2-2010) for the individual to present at time of application.
Spouse and each dependent must submit a separate application.	Spouse and each dependent must submit a separate application.		The spouse and each dependent of a TAARA qualified individual are required to complete a separate application. Place the TAARA eligible individual's name in section 6 of the application.
			The individual is required to secure health care coverage through a HCTC qualified plan.

COBRA ELIGIBLES

Traditional	Age 65 & Over or Disabled	HIPAA	TAARA
Plans allow enrollment by individuals eligible for COBRA or guaranteed issue.	Plans allow enrollment by individuals eligible for COBRA or guaranteed issue.	Allows enrollment by individuals eligible for COBRA or guaranteed issue provided written or verbal confirmation the individual has either: <ol style="list-style-type: none"> 1. declined continuation coverage offered by his/her employer when it was first available; or 2. elected continuation coverage through his/her employer and has exhausted the COBRA coverage extension. 	Plans allow enrollment by individuals eligible for COBRA who elect to obtain this coverage.
A business owner is not eligible for COBRA.	A business owner is not eligible for COBRA.	A Certificate of Coverage (COC) confirming a prior coverage end date that is concurrent to the <u>effective date</u> of the CHAND plan is evidence the individual has declined COBRA coverage.	A business owner is not eligible for COBRA.
		COBRA continuation letters submitted with HIPAA applications <u>are not</u> considered a COC.	
		A business owner is not eligible for COBRA.	

Dates on Applications – General

All Plans

Any application that requires a change to the [effective date](#) of the policy due to an incorrect or not allowed date on the application:

- If the applicant is not present, the [effective date](#) must be the latter of the original date or the revised date. Lead Carrier will document the applicant's agreement and attach the correspondence to the application.
- Exceptions provided all other criteria and timelines are met:
 - 1) An individual applying with a rejection or refusal may go back to the day following the date on the rejection letter; and,
 - 2) an individual applying due to reaching a lifetime max may go back to the day the lifetime maximum was reached.
- If the applicant is present, the applicant must initial any changes to the [effective date](#) shown on the application.

Any application that requires a change to the [effective date](#) of the policy because there are better options available:

- The applicant will be contacted and provided with options to assist with securing coverage:
 - 1) for an entire one-half month (ie app states 6/19 effective date but individual would qualify for a 6/16 date so financially it is beneficial to take the 6/16 date when eligible;
 - 2) on the beginning of the month (ie app state 6/30 effective date but individual would qualify for 7/1 date and would save one-half month's premium by taking the first of the month.
 - 3) if moving the date to either the date after the rejection letter or signature date, would provide a qualified applicant to enter CHAND without waiting periods.

Any application that is submitted without an effective date:

- Applicant will be contacted and advised of the effective date options based on eligibility, signature date, and evidence of eligibility as well as notified of the waiver of waiting period options, if any.
- UW will be notified of decision made by subscriber.
 - 1) Date will be documented in correspondence control
 - 2) UW will change the date on the application and initial the change with a copy of the correspondence control attached to the application.

No CHAND policy may have an effective date that is a date between the date shown on the evidence of eligibility and the signature date.

The only applicants that may have an effective date prior to the signature date of application are:

- Traditional applicant entering CHAND with a rejection or refusal;
- Supplement applicant entering CHAND with a rejection or refusal; or,
- Traditional applicant entering CHAND due to reaching the Lifetime Maximum benefit on a different plan.

Premiums to the retroactive coverage date must accompany the application.

Applications with a [signature date](#) that is prior to the date of any written evidence of eligibility will be returned with the premium to the applicant or the signing agent.

- A new application will be required.
- A different effective date than what was initially requested may also be required.

HIPAA and TAARA

An individual who is still covered through qualifying previous coverage may submit an application.

- The effective date must follow termination of the current coverage but may not exceed 63 days of the expected coverage termination date.

Any individual who requests a different effective date after the application has been set up (ie – id cards and benefit plans issued; subscriber is eligible to have claims processed on their behalf; etc,) must complete the following within ten (10) working days of the application completion date shown on the application:

- Request cancellation of the policy in writing or verbally followed expediently by a written request.
 - 1) Any claims paid between the effective date and the cancellation date will be reprocessed as unpaid.
 - 2) Premiums paid for coverage between the effective date and the cancellation date will be returned.
- Individual cannot apply prior to the initial policy being cancelled.
 - 1) Individual will be notified when the plan has been cancelled.
 - 2) A new application with new premium will be required.

Dates on Applications – Effective

Traditional

	On the signature date of application.	On the day following the date shown on the written rejection or refusal if signed less than 180 days following the date shown on the written rejection or refusal.	On the signature date of application if signed at least one day after and less than 180 days following the date shown on the written rejection or refusal.	Any date after the signature date if the selected effective date is at least one day after and less than 180 days following the date shown on the written rejection or refusal.	On the signature date of application if signed on the date or within 180 days following the date of written evidence of restrictive rider/PE or excessive rate, or medical condition.	Any date after the signature date if the selected effective date is at least the date or within 180 days following the date of written evidence of restrictive rider/PE or excessive rate, or medical condition.	On the date the lifetime maximum occurred if the application is submitted within 90 days after the date that the lifetime maximum occurred and the application is accompanied by premium for coverage retroactive to the date that the lifetime maximum occurred.
Rejected or refused similar insurance for health reasons		X	X	X			
Offered coverage with a restrictive rider or PE limit that substantially reduces coverage					X	X	
Offered comparable insurance at a rate exceeding CHAND					X	X	
Existence or history of medical condition on application					X	X	
Resident dependent of a CHAND subscriber	X						
Resident spouse of a CHAND subscriber	X						
Reached lifetime maximum amount on most recent health insurance							X

Dates on Applications – Signature Dates

Traditional	Age 65 & Over or Disabled	HIPAA	TAARA
The signature date may not be prior to the date shown on the qualifying document(s) of evidence of eligibility .	The signature date may not be prior to the date shown on the qualifying document(s) of evidence of eligibility .	The signature date may not be prior to the date shown on the qualifying document(s) of evidence of eligibility .	The signature date may not be prior to the date of eligibility.
Spouse or dependent: any date following enrollment of qualifying individual.	Spouse or dependent: any date following enrollment of qualifying individual.		EXCEPTION: An individual who is still covered through qualifying previous coverage may submit an application. The effective date must be following termination of the current coverage but within the 63-days of the expected coverage termination date.
Rejection/refusal: <ul style="list-style-type: none"> the date shown on the evidence of eligibility; within 180 days following the date on the evidence of eligibility; or Any date after the signature date that is at least one day after and less than 180 days following the date on the evidence of eligibility. 	Rejection/refusal: <ul style="list-style-type: none"> the date shown on the evidence of eligibility; within 180 days following the date on the evidence of eligibility; or Any date after the signature date that is at least one day after and less than 180 days following the date on the evidence of eligibility. 		
Restrictive rider/PE; excessive rates; or, a medical condition: <ul style="list-style-type: none"> the signature date of application if signed within 180 days following the date on the evidence of eligibility; or Any date after the signature date that is within 180 days following the date on the evidence of eligibility. 	Restrictive rider/PE; excessive rates; or, a medical condition: <ul style="list-style-type: none"> the signature date of application if signed within 180 days following the date on the evidence of eligibility; or Any date after the signature date that is within 180 days following the date on the evidence of eligibility. 		
Reaching Lifetime Maximum: on the date the LTM occurred if the application is signed within 90 days following the date the lifetime maximum was met.			
Applications with a signature date that is prior to the date of any written evidence of eligibility will be returned with the premium to the applicant or the signing agent. A new application will be required. A different effective date than what was initially requested may also be required.			

Dates on Applications – Signature Dates

Traditional	Age 65 & Over or Disabled	HIPAA	TAARA
The signature date may not be prior to the date shown on the qualifying document(s) of evidence of eligibility .	The signature date may not be prior to the date shown on the qualifying document(s) of evidence of eligibility .	The signature date may not be prior to the date shown on the qualifying document(s) of evidence of eligibility .	The signature date may not be prior to the date of eligibility.
Spouse or dependent: any date following enrollment of qualifying individual.	Spouse or dependent: any date following enrollment of qualifying individual.		EXCEPTION: An individual who is still covered through qualifying previous coverage may submit an application. The effective date must be following termination of the current coverage but within the 63-days of the expected coverage termination date.
Rejection/refusal: <ul style="list-style-type: none"> the date shown on the evidence of eligibility; within 180 days following the date on the evidence of eligibility; or Any date after the signature date that is at least one day after and less than 180 days following the date on the evidence of eligibility. 	Rejection/refusal: <ul style="list-style-type: none"> the date shown on the evidence of eligibility; within 180 days following the date on the evidence of eligibility; or Any date after the signature date that is at least one day after and less than 180 days following the date on the evidence of eligibility. 		
Restrictive rider/PE; excessive rates; or, a medical condition: <ul style="list-style-type: none"> the signature date of application if signed within 180 days following the date on the evidence of eligibility; or Any date after the signature date that is within 180 days following the date on the evidence of eligibility. 	Restrictive rider/PE; excessive rates; or, a medical condition: <ul style="list-style-type: none"> the signature date of application if signed within 180 days following the date on the evidence of eligibility; or Any date after the signature date tat is within 180 days following the date on the evidence of eligibility. 		
Reaching Lifetime Maximum: on the date the LTM occurred if the application is signed within 90 days following the date the lifetime maximum was met.			
Applications with a signature date that is prior to the date of any written evidence of eligibility will be returned with the premium to the applicant or the signing agent. A new application will be required. A different effective date than what was initially requested may also be required.			

Dependents

Traditional, an Age 65 & Over or Disabled, or a HIPAA

Any North Dakota [resident](#) who is a dependent of an individual who is enrolled as a CHAND **Traditional, an Age 65 & Over or Disabled, or a HIPAA** subscriber is also eligible for CHAND coverage.

- Each dependent will need to complete a separate **Traditional or Age 65 and Over or Disabled** application and provide appropriate premium.
- A 180-day waiting period will apply.
- A certificate of creditable coverage can be used to allow a reduction in waiting period days.
- A representative from the Lead Carrier will confirm [eligibility by verifying the enrollment status of the qualifying subscriber](#).
-

TAARA

Any North Dakota [resident](#) who is a dependent of a CHAND **TAARA** individual is also eligible for CHAND coverage.

- Each dependent will need to be named on the HCTC Eligibility Certificate (Letter #L3779 Revised 2-2010) from Health Care Tax Credit.
- Each dependent will need to complete a separate **TAARA** application and provide appropriate premium.
- A representative of the Lead Carrier will confirm [eligibility](#) as determined by Health Care Tax Credit eligibility.
-

Eligibility Requirements

Traditional Applicants

The applicant is eligible to apply for coverage because he/she:

1. Has been a [resident](#) of North Dakota for at least 183 days prior to this application and intends to maintain North Dakota residency while a subscriber of CHAND; **and**

2. Meets one of the following:

a, Is a:

- resident [dependent](#) of a CHAND subscriber; or
- resident [spouse](#) of a CHAND subscriber.

OR

b. Has included [written evidence](#) from at least one insurance carrier that within 180 days prior to the [signature date](#) of application he/she has been:

- [Rejected of refused by an insurer to issue substantially similar insurance for health reasons;](#)
- [Offered coverage with a restrictive rider or a preexisting condition limitation in place on the policy, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk;](#) or
- [Offered a comparable insurance at a rate that exceeds the CHAND rate.](#)

OR

c. [Has included written evidence from a medical professional of the existence or history of any of the following:](#)

- AIDS – Alzheimer’s disease – Cirrhosis – COPD/Emphysema – Crohn’s disease – Dementia – End stage renal failure – Hemiplegia/paraplegia if result of CVA – Hemochromatosis – Hemophilia – Multiple sclerosis – Muscular dystrophy – Nursing home resident – Obesity – Polycythemia – Pregnancy – Quadriplegia – Severe osteoarthritis

OR

d. Has included within 90 days after the date, [written evidence](#) that my lifetime maximum coverage amount was reached on my most recent health insurance coverage. (Premium for coverage retroactive to the date that the lifetime maximum occurred is required to be submitted with the application.)

and

3. Is not enrolled in health benefits with the state of North Dakota’s Medical Assistance Program ([Medicaid](#)); **and**

4. Is not [imprisoned](#) under federal, state or local authority; **and**

5. Does not have health insurance [premiums paid for or reimbursed](#) under any government-sponsored program, government agency, health care provider, nonprofit charitable organization or employer; **and**

6. Has not been [previously insured through CHAND](#) during the past 12 months. (This does not apply to an applicant who has applied under 2d above.)

Eligibility Requirements

HIPAA Applicants

The applicant is eligible to apply for coverage because he/she:

1. Is a [resident](#) of North Dakota and intends to maintain North Dakota residency while a subscriber of CHAND; **and**

2. Meets the following federally-defined eligibility guidelines:

Has had 18 months of qualifying previous coverage* ; **and**

***Qualifying Previous Coverage** – 1) group health benefit plan; 2) health benefit plan; 3) Medicare; 4) Medicaid; 5) TRICARE; 6) Indian Health Services; 7) state risk pool coverage; 8) health plan under §5 U.S.C. 89; 9) public health plan; 10) health benefit plan §5(e) of the Peace Corps Act; and, 11) state children's health insurance.

3. Has [applied for coverage within 63 days](#) of the termination of the qualifying previous coverage; **and**

Is not eligible for coverage under [Medicare](#) or a group health benefit plan; **and**

Does not have any other health insurance coverage; **and**

Has not had the most recent qualifying previous coverage terminated for [nonpayment of premiums or fraud](#); **and**

If offered the option, has declined continuation coverage under COBRA through his/her employer or under a similar state program and that coverage has been exhausted. **and**

4. Is not enrolled in health benefits with the state of North Dakota's Medical Assistance Program ([Medicaid](#)); **and**

5. Does not have [health insurance premiums paid for or reimbursed](#) under any government-sponsored program, government agency, health care provider, nonprofit charitable organization or employer.

Eligibility Requirements

Age 65 & Over or Disabled Applicants

The applicant is eligible to apply for coverage because he/she:

1. Is at least 65 years old or disabled and eligible for Medicare; **and**
2. Has been a [resident](#) of North Dakota for at least 183 days prior to this application and intend to maintain North Dakota residency while a subscriber of CHAND; **and**
3. Meets one of the following:
 - a. Is a
 - resident [dependent](#) of a CHAND subscriber; or
 - resident [spouse](#) of a CHAND subscriber.
 - OR**
 - b. Has included [written evidence](#) from at least one insurer that within 180 days prior to the [signature date](#) of application he/she has been:
 - [Rejected of refused by an insurer to issue substantially similar insurance for health reasons;](#)
 - [Offered coverage with a restrictive rider or a preexisting condition limitation in place on the policy, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk;](#) or
 - [Offered a comparable insurance at a rate that exceeds the CHAND rate.](#)
 - OR**
 - c. [Has included written evidence from a medical professional of the existence or history of any of the following:](#)
 - AIDS – Alzheimer’s disease – Cirrhosis – COPD/Emphysema – Crohn’s disease – Dementia – End stage renal failure – Hemiplegia/paraplegia if result of CVA – Hemochromatosis – Hemophilia – Multiple sclerosis – Muscular dystrophy – Nursing home resident – Obesity – Polycythemia – Pregnancy – Quadriplegia – Severe osteoarthritis **and**
4. Is not enrolled in health benefits with the state of North Dakota’s Medical Assistance Program ([Medicaid](#)); **and**
5. Is not [imprisoned](#) under federal, state or local authority; **and**
6. Does not have health insurance [premiums paid for or reimbursed](#) under any government-sponsored program, government agency, health care provider, nonprofit charitable organization or employer; **and**
7. Has not been [previously insured through CHAND](#) during the past 12 months.

Eligibility Requirements

TAARA Applicants

The applicant is eligible to apply for coverage because he/she:

1. Has been a [resident](#) of North Dakota for at least 183 days prior to this application and intends to maintain North Dakota residency while a subscriber of CHAND; **and**
2. Is a Trade Adjustment Assistance or a Pension Benefit Guarantee Corporation applicant; **and** *(Requires a HCTC Eligibility Certificate (Letter #L3779 Revised 2-2010) Letter from HCTC)* **and**
3. Has had three or more months of qualifying previous health insurance coverage; **and**
4. Has [applied for coverage within 63 days of termination](#) of qualifying previous health insurance coverage; **and**
5. Is not [imprisoned](#) under federal state or local authority; **and**
6. Is not enrolled in health benefits with the state of North Dakota's Medical Assistance Program ([Medicaid](#)); **and**
7. Has not been [previously insured through CHAND](#) during the past 12 months; **and**
8. Does not have health insurance coverage through any of the follows:
 - a. His/Her or his/her spouse's employer plan that provides for employer contribution of 50% or more of the cost of coverage for the applicant, his/her spouse and his/her eligible dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan;
 - b. North Dakota's children's health insurance program (Healthy Steps);
 - c. A government plan;
 - d. Chapter 55 or United States Code Title 10 related to armed forces medical and dental care; or
 - e. [Medicare](#); **and**
9. Coverage under this program may be provided to an applicant who is eligible for health insurance coverage through: COBRA [Pub.L. 99-272]; a spouse's employer program in which the employer contribution is less than 50%; or the individual marketplace, including continuation or guaranteed issue, but who elects to obtain this coverage.

Evidence of Eligibility - General

Traditional and Age 65 & Over or Disabled Applicants

If the application is submitted without written [evidence of eligibility](#), the application will not be accepted.

- The Lead Carrier will disapprove the application and return the premium with a copy of the application.
- The reason for disapproval will be provided in writing to the applicant and/or agent.
- The applicant will need to provide a new application.

Exception: An individual applying as a dependent or spouse of CHAND subscriber. Reference [Spouse](#) or [Dependent](#) sections.

HIPAA Applicants

If the application is submitted with the first page completed, but the applicant fails to complete the second page or does not provide any type of [evidence of eligibility](#), the application is not considered complete.

- The Lead carrier will contact the applicant to request some type of acceptable evidence.
- If the applicant provides the information to the Lead Carrier prior to 30 days from receipt of the application, the Lead Carrier will process the application and if approved, honor the original application dates.
- If the applicant does NOT provide the information to the Lead Carrier prior to 30 days from receipt of the application, the Lead Carrier will disapprove the application and refund the premium.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.
- The 63-day HIPAA time period will not stop until this evidence is received.

If an application is submitted with the first and second pages completed, but the applicant fails to provide some type of evidence of eligibility, the application will be accepted if it provides enough information for the Lead Carrier to verify the applicant's eligibility.

- The 63-day HIPAA time period will stop upon receipt by the Lead Carrier.
- Verification of eligibility may require the Lead Carrier to telephonically contact the applicant's former insurer or employer to verify previous coverage.
- If the applicant provides the information within the timeframe, the Lead Carrier will process the application and if approved, honor the original application dates.
- If the applicant does NOT provide the information within the timeframe, the Lead Carrier will disapprove the application and refund the premium.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.

TAARA Applicants

If the application is submitted without evidence of eligibility, the application will not be accepted.

- The Lead Carrier will disapprove the application and refund the premium.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.

The acceptance of a TAARA application does not guarantee the individual is or will continue to be eligible for HCTC payments or credits. Additionally, the HCTC Eligibility Certificate (Letter #L3779 Revised 2-2010) does not guarantee an individual is eligible for CHAND TAARA coverage.

Evidence of Eligibility - Written

Traditional and Age 65 & Over or Disabled Applicants

Select the appropriate written [evidence of](#) eligibility to identify the specific requirement:

1) Letter of rejection or refusal from an insurer to issue insurance for health reasons.

- A letter from the insurance carrier's home office on the carrier's letterhead that states the applicant has been denied coverage from his/her company due to health reasons is required.
- The date on the letter may be no more than 180 days prior to the [signature date](#) on the CHAND application.
- Letters signed by agents representing an insurance company cannot be accepted.
- A rejection or refusal by an insurer offering only stop loss, excess of loss, or reinsurance coverage is not sufficient evidence to qualify as a rejection or refusal.
- A conversion letter may be accepted as a rejection letter.

2) Letter from an insurer indicating that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered standard risk, is in place on the policy the insurer is willing to offer.

- A letter from the insurance carrier's home office on the carrier's letterhead that states the applicant has been offered restrictive coverage is required.
- The date on the letter may be no more than 180 days prior to the [signature date](#) on the CHAND application.
- Letters signed by agents representing an insurance company cannot be accepted.
- A restrictive rider is a modification to an existing benefit plan that applies to a specific individual and restricts benefits that are normally offered to others having the same benefit plan. A restrictive rider is not a limited benefit plan, which allows a limit of benefits for some condition(s) that applies to all members of the benefit plan.
- A preexisting condition period is a limit that has been placed on an individual's policy, not a general limitation that applies to all members of the benefit plan. A policy with a standard waiting limit of 12 months does not qualify the individual for CHAND.

NOTE: Individuals who are covered under a limited benefit plan versus having a restrictive rider or preexisting condition limitation, need to get a rejection letter to be eligible for CHAND coverage as a Traditional applicant.

3) Letter from an insurer offering comparable insurance at a rate exceeding the CHAND rate.

- Written documentation from the insurance carrier's computer system or a comparison printed on the company's letterhead and signed by a representative or licensed agent is required.
- The date on the letter may be no more than 180 days prior to the [signature date](#) on the CHAND application

4) Letters from a health care professional certifying an individual is applying due to the existence or history of any of the medical condition(s) shown on the application.

- The written confirmation must be on the letterhead of the health care professional who is certifying the condition.
- The condition must be listed on the CHAND application.
- The date on the letter may be no more than 180 days prior to the [signature date](#) on the CHAND application

5) Document from an insurance carrier that shows the lifetime maximum coverage benefit has been reached and the date that the coverage terminated.

*****This does not apply to an Age 65 and Over or Disabled applicant.*****

TAARA Applicants

A Federal Health Care Tax Credit (HCTC) HCTC Eligibility Certificate (Letter #L3779 Revised 2-2010) to certify the applicant meets the requirements of the Trade Adjustment Assistance or Pension Benefit Guarantee Corporation guidelines will be required to apply as a TAARA applicant.

A Certificate of Coverage or other documentation from the prior carrier to show previous coverage and its termination date is also required.

Imprisoned Individual

Traditional – Age 65 & Over or Disabled - TAARA

An individual who is imprisoned under federal, state, or local authority is not eligible to enroll as a CHAND subscriber.

HIPAA

There is not an imprisonment restriction applied to an individual who is applying to CHAND as a HIPAA applicant.

Invalid Applications - General

Applies to all CHAND Applications

If an application is submitted without premium or signatures, the application will not be accepted.

- The Lead Carrier will disapprove the application and returned it with the premium to the applicant or the signing agent.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.
- A different effective date than what was initially requested may also be required.

If an application is submitted with a signature date prior to the date on the evidence of eligibility.

- The Lead Carrier will disapprove the application and returned it with the premium to the applicant or the signing agent.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.
- A different effective date than what was initially requested may also be required.

Traditional and Age 65 and Over or Disabled

If an application is submitted more than 180 days after the date of evidence of eligibility.

***** This does not apply to Traditional applicants who have reached their lifetime maximum on a different carrier. See section immediately below.**

- The Lead Carrier will disapprove the application and returned it with the premium to the applicant or the signing agent.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application and evidence of eligibility that is current to within 180 days of application.
- A different effective date than what was initially requested will be required.

If an application is submitted more than 90 days after the date the lifetime maximum was met.

- The Lead Carrier will disapprove the application and returned it with the premium to the applicant or the signing agent.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to submit a new application and evidence of eligibility as a Traditional or HIPAA applicant but may not reapply as an individual who has reached his/her lifetime maximum.
- **A different effective date than what was initially requested will be required and a lapse in coverage will be in place.**

Traditional - Age 65 and Over or Disabled - TAARA

If the application is submitted with the premium and written evidence of eligibility within the appropriate timeframes but is missing other information, the application will be accepted.

- The Lead Carrier will contact the applicant to request the missing information.
- The applicant will be given a specific period of time to fulfill the request.
- If the applicant provides the information within the timeframe, the Lead Carrier will process the application and if approved, honor the original application dates.
- If the applicant does NOT provide the information within the timeframe, the Lead Carrier will disapprove the application and refund the premium.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.

If an application is submitted with premium but does not have without evidence of eligibility.

- The Lead Carrier will disapprove the application and returned it with the premium to the applicant or the signing agent.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.
- A different effective date than what was initially requested may also be required.

Invalid Applications – General, continued

HIPAA and TAARA

If an application is submitted with a signature date that is more than 63 days following termination of the applicant's qualifying previous coverage, the application will not be accepted.

- The Lead Carrier will disapprove the application and returned it with the premium to the applicant or the signing agent.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application and evidence of eligibility as a Traditional applicant but may not reapply as an HIPAA or TAARA applicant.
- A different effective date than what was initially requested will be required.

Completed applications submitted with premium but without evidence of eligibility

- Prior to disapproving the application and returning premium, it will be pended for 30 days while the Lead Carrier attempts to collect proof of eligibility.

HIPAA Applicants

If the application is submitted with the premium and the first page completed, but the applicant fails to complete the second page or does not provide any type of evidence of eligibility, the application is not considered complete.

- The Lead carrier will contact the applicant to request some type of acceptable evidence.
- The 63-day HIPAA time period will stop upon receipt by the Lead Carrier but the application will not be processed until this evidence is received.
- If the applicant provides the information to the Lead Carrier prior to 30 days from receipt of the application, the Lead Carrier will process the application and if approved, honor the original application dates.
- If the applicant does NOT provide the information to the Lead Carrier prior to 30 days from receipt of the application, the Lead Carrier will disapprove the application and refund the premium.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.

If an application is submitted with the premium and the first and second pages are completed, but the applicant fails to provide some type of evidence of eligibility, the application will be accepted if it provides enough information for the Lead Carrier to verify the applicant's eligibility.

- The 63-day HIPAA time period will stop upon receipt by the Lead Carrier.
- Verification of eligibility may require the Lead Carrier to telephonically contact the applicant's former insurer or employer to verify previous coverage.
- If the applicant provides the information within the timeframe, the Lead Carrier will process the application and if approved, honor the original application dates.
- If the applicant does NOT provide the information within the timeframe, the Lead Carrier will disapprove the application and refund the premium.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.

Invalid Applications - Reapplication

Traditional - All Applicants

No CHAND policy may have an effective date that is a date between the date shown on the evidence of eligibility and the signature date.

Traditional and Age 65 & Over or Disabled – Spouse & Dependents

Requires a new application with new signature and effective dates.

- The new effective date will be the signature date of the new application.
- The effective date may not be retroactive to the effective date or signature date on the original application.

Traditional and Age 65 & Over or Disabled – Rejection

Requires a new application with new signature that is within 180 days of the evidence of eligibility.

- The effective date may be the day following the date of rejection or refusal; the signature date of the new application or any date after the signature date but less than 180 days after the date on the evidence of eligibility.

Traditional and Age 65 & Over or Disabled – Restrictive Rider, Excessive Rate, Medical Condition

Requires a new application with new signature that is within 180 days of the evidence of eligibility.

- The effective date may be the signature date of the new application or any date after the signature date but less than 180 days after the date on the evidence of eligibility.
- The effective date may not be retroactive to the effective date or signature date on the original application.

Traditional Applicants – Lifetime Maximum Met

Requires a new application with new signature that is within 90 days of the date the lifetime maximum was reached.

- The effective date will be retroactive to the date the lifetime maximum was reached. The application must include premium retroactive to the date the lifetime maximum was reached.
- The effective date may not be retroactive to the effective date or signature date on the original application.

HIPAA and TAARA

Requires a new application with a new signature that is within 63 days of termination of the applicant's creditable coverage.

- The effective date may be the signature date of the new application or any date after the signature date but less than 63 days after termination of the applicant's creditable coverage.
- The effective date may not be retroactive to the effective date or signature date on the original application.

Lifetime Maximum Benefit

All Applicants

The Lead Carrier records membership and accumulator data.

- The Lead Carrier, as a component of the [application review process](#), determines [eligibility](#) and benefit limits prior to approving the application.

The Lead Carrier's program administrator will notify CHAND subscribers when his/her benefit dollars paid nears the lifetime maximum and assist in determining alternative options for health care coverage.

Traditional and TAARA Applicants

Any individual who has entered the CHAND program and a Traditional or TAARA applicant and has received benefits of one million dollars through the CHAND program may apply for coverage on a HIPAA CHAND plan.

- If the applicant meets the HIPAA eligibility requirements, they are eligible to receive an additional one million dollars in benefits through CHAND. Reference Moving between Plans.

Age 65 and Over or Disabled Applicants

Any individual who has received benefits of one million dollars through the CHAND program is not eligible to receive additional funds from the program.

- Age 65 and Over or Disabled applicants are not eligible to move to a HIPAA plan for an additional one million in benefits due to his/her eligibility for Medicare A & B.

HIPAA Applicants

Any individual who has entered the CHAND program as a HIPAA applicant and has received benefits of one million dollars through the CHAND program is not eligible to receive an additional one million dollars in benefits through CHAND. (Ref. directive from CMS)

Medicaid

All Applicants

An applicant who is enrolled in health benefits with the state's medical assistance program (Medicaid) is not [eligible](#) to enroll as a CHAND subscriber.

- If an individual is active within the Medicaid system, the individual is enrolled in Medicaid.
- Enrollment with Medicaid, regardless of an individual's eligibility for benefits on a month-to-month basis, disqualifies an individual from CHAND.

Medicaid coverage, once terminated, has the status equivalent to other insurance plans and therefore is considered qualifying previous coverage.

An applicant may not sign a CHAND application while enrolled with Medicaid.

Written certification from the state's Medicaid program, which certifies that the individual is no longer enrolled or eligible for Medicaid benefits, is required at the time the CHAND application is signed.

If a CHAND subscriber becomes enrolled with Medicaid, they will be cancelled off of CHAND at the end of the month that CHAND becomes aware of the Medicaid enrollment.

- Termination will not be retroactive to the effective date of Medicaid enrollment.
- Premiums will not be refunded retroactively to the effective date of Medicaid enrollment.

Medicare

All Applicants

CHAND's prescription drug coverage is creditable. A Creditable Coverage Disclosure Notice (CCDN) is provided for the Traditional subscribers on a yearly basis and posted to the CMS website.

An individual who becomes eligible for Medicare due to age or disability cannot be forced to move to a CHAND supplement. These individual may maintain his/her coverage through CHAND with a Traditional policy.

A CHAND enrollee who terminates CHAND coverage to enroll in a Medicare Advantage plan may be allowed to re-apply to CHAND within 12 months of switching to a Medicare Advantage plan. The 12-month break in CHAND coverage does not apply in this situation.

CHAND considers Medicare A & B coverage as qualifying previous coverage.

Traditional Applicants

An applicant who is eligible for or enrolled in Medicare A & B, due to age or disability, may be eligible to enroll as a Traditional CHAND subscriber.

An applicant who is eligible for or enrolled in Medicare A & B, due to age or disability, *AND* has a commercial Medicare Supplement policy may be eligible to enroll as a Traditional CHAND while maintaining the commercial Medicare Supplement policy.

Age 65 & Over or Disabled Applicants (Basic and Standard Supplements)

An applicant who is eligible or enrolled in Medicare A & B may be eligible to enroll as an Age 65 & Over or Disabled CHAND subscriber.

Although CHAND is not a Medicare Supplement policy, a CHAND Age 65 and Older or Disabled supplement policy may not be sold to an individual who is already covered by a commercial Medicare Supplement Policy.

An individual who purchase's CHAND's Age 65 and Older or Disabled Supplement policy does not need to complete a Medicare Supplement Replacement form.

HIPAA and TAARA Applicants

An applicant who is eligible or enrolled in Medicare A & B is not eligible to enroll as a HIPAA or TAARA CHAND subscriber.

Medicare Advantage – Returning to CHAND

Age 65 & Over or Disabled Applicants - (Basic and Standard Supplements)

A CHAND enrollee that terminates CHAND coverage to enroll in a Medicare Advantage plan may be allowed to re-apply for CHAND coverage within twelve months of switching to a Medicare Advantage plan, notwithstanding the language in NDCC 26.1-08-12(12)(b) that provides that an individual is not eligible for coverage for 12 months once the individual terminates the CHAND coverage.

This does not apply to Medicare Cost Plans.

Medicare Advantage Plan versus Medicare Cost Plans:

- Medicare Advantage Plans provide all of your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage and must cover all medically necessary services that are covered under Part A or Part B. They generally offer extra benefits, and most also include Medicare prescription drug coverage (Part D).
- Medicare Cost Plan is a type of HMO that is available in certain areas of the country. You can join even if you only have Part B. If you go to a non-network provider, the services are covered under Original Medicare. You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a stand-alone Medicare Prescription Drug Plan to add prescription drug coverage.

How to Process

The prior enrollee must provide proof to verify the product they are transferring from is a true Medicare Advantage Plan.

- Their Medicare Advantage benefit plan or a statement from the carrier is required.

The cancellation date must also be provided.

- If the carrier will not provide the cancellation date, a statement from the applicant may be accepted.

A denial letter or other proof of eligibility is not required.

- Underwriting will confirm prior coverage and that cancellation of the prior CHAND Age 65 and Over or Disabled policy is less than 12 months.

The effective date may be the date they reapply for the CHAND Age 65 and Over or Disabled product.

- An effective date that is retroactive to the date the original CHAND Age 65 and over or Disabled policy was cancelled is not allowed.
- An effective date that is retroactive to the date the Medicare Advantage policy was cancelled is not allowed.

Moving between CHAND Plans

All Applicants

The 12-month lapse in coverage requirement does not apply to CHAND subscribers who have continuous CHAND coverage and are moving between CHAND plans.

Traditional – HIPAA – TAARA Enrollees

A subscriber may change his/her chiropractic option annually on anniversary (September 1).

- A written request is required.
- An application is not required.

A subscriber with a \$500 deductible may move to a \$1000 deductible at the end of any month.

- A written request is required.
- An application is not required.

A subscriber with a \$1000 deductible may move to a \$500 deductible on anniversary (September 1).

- A written request is required.
- An application is not required.

Traditional Enrollees

An individual on a Traditional CHAND plan who becomes eligible for Medicare due to age will be notified by the Lead Carrier through a “Nearing Age 65” letter of his/her ability to move to a supplement plan with a commercial carrier of his/her choice without medically qualifying if done within six months of becoming eligible for [Medicare](#).

If the Traditional subscriber fails to move to a commercial carrier’s supplement within the six- month window of becoming eligible due to age the subscriber may:

1) Move to a CHAND Supplement plan at any time.

- An application is required but the individual does not need to provide new evidence of eligibility.
- No waiting period is applied.
- Membership will complete the transfer effective at the end of the month following notification of Medicare eligibility and receipt of application.

2) Remain on a Traditional policy.

- No additional action is necessary.

A Traditional CHAND individual, who is or becomes eligible for [Medicare due to a disability](#), may move to a Basic or Standard supplement plan.

- An application is required but the individual does not need to provide new evidence of eligibility.
- Documentation of Medicare eligibility due to a disability is required.

If the notification is made verbally through the CHAND Service Center, the representative will inform the subscriber of his/her option to transfer to a Traditional or Supplement CHAND plan:

* The CHAND Service Center representative will provide website information to the subscriber or send a request through the IBC process to ensure an agent contacts the subscriber.

* Correspondence will be sent to membership to terminate the coverage at the end of the month and complete the transfer.

- No waiting period is applied.
- Membership will complete the transfer effective at the end of the month following notification of Medicare eligibility and receipt of application.

Moving between CHAND Plans

HIPAA and TAARA Enrollees

A HIPAA or TAARA subscriber who becomes eligible for Medicare due to age will be notified by the Lead Carrier through a "Nearing Age 65" letter that he/she is ineligible to remain on CHAND as a HIPAA or TAARA subscriber but able to move to a supplement plan with a commercial carrier of his/her choice without medically qualifying if done within six months of becoming eligible for Medicare due to age.

If the HIPAA or TAARA subscriber fails to move to a commercial carrier's supplement within the six-month window of becoming Medicare eligible due to age the subscriber must move to a CHAND Traditional or Supplement plan to maintain eligibility with CHAND.

- An application is required but the individual does not need to provide new evidence of eligibility.
- A CHAND Service Center representative will contact the subscriber provide website information to the subscriber or send a request through the IBC process to ensure an agent contacts the subscriber.
- No waiting period is applied.
- Membership will complete the transfer effective at the end of the month following notification of Medicare eligibility and receipt of application.

A HIPAA or TAARA CHAND individual who becomes eligible for Medicare due to disability must move to a CHAND Traditional or Supplement plan to maintain eligibility with CHAND.

- An application is required but the individual does not need to provide new evidence of eligibility.
- Documentation of Medicare eligibility due to a disability is required.
If the notification is made verbally through the CHAND Service Center, the representative will inform the subscriber of his/her option to transfer to a Traditional or Supplement CHAND plan:
 - * The CHAND Service Center representative will provide website information to the subscriber or send a request through the IBC process to ensure an agent contacts the subscriber.
 - * Correspondence will be sent to membership to terminate the coverage at the end of the month and complete the transfer.
- No waiting period is applied.
- Membership will complete the transfer effective at the end of the month following notification of Medicare eligibility and receipt of application.

Traditional and TAARA Enrollees

Any individual who has entered the CHAND program and a Traditional or TAARA applicant and has received benefits of one million dollars through the CHAND program may apply for coverage on a HIPAA CHAND plan and receive an additional one million dollars in benefits through CHAND.

- An application is required.
- The individual must meet the HIPAA eligibility requirements.
- Proof of qualifying previous coverage will be provided by the Lead Carrier.
- The effective date will be the date the lifetime maximum was reached.
- Premium for coverage retroactive to the date that the lifetime maximum occurred is required to be submitted with the application.

Directive from CMS 12/15/09; approved by CHAND board 4/22/10.

Moving between CHAND Plans

Age 65 & Over or Disabled (Basic and Standard Supplement Enrollees)

A Standard Supplement subscriber may move to a Basic Supplement at anytime.

- A written request is required.
- An application is not required.

A Basic Supplement subscriber may move to a Standard Supplement only on anniversary. (January 1)

- A written request is required.
- An application is not required.

A Standard or Basic Supplement subscriber may move to Traditional CHAND coverage on the Supplement anniversary. (January 1)

- An application is required but the individual does not need to provide new evidence of eligibility.
- Traditional plan must have a concurrent [effective date](#).
- Medicare A & B and Medicare Supplement are qualifying previous coverage so no waiting period will apply.

An individual on a Supplement CHAND plan who is eligible for [Medicare due to a disability](#) then becomes eligible for [Medicare due to age](#) will be notified of his/her ability to move to a supplement plan with a commercial carrier of his/her choice without medically qualifying if they do so within six months of becoming eligible for [Medicare](#).

If the Supplement subscriber fails to move to a commercial carrier's supplement within the six-month window of becoming [Medicare](#) eligible [due to age](#) the subscriber will remain on a CHAND Supplement plan until CHAND is notified of any change.

A Supplement subscriber who is no longer eligible for [Medicare](#) must move to a Traditional plan.

- Change will take place at the end of the month in which CHAND becomes aware of the Medicare eligibility.
- An application is required but the individual does not need to provide new evidence of eligibility.
- Waiting periods do not apply.

Newborns

A newly born child without health insurance coverage is covered through the mother's association benefit plan for the first 31 days following birth. This includes a child who is adopted from the date of adoption through the first 31 days following birth.

- The newborn will not be automatically added to the mother's policy.

A representative from the Lead Carrier will confirm if the newborn is eligible to be added to a different insurance coverage.

a) If the child is eligible to be added to insurance coverage other than the mother's CHAND policy, the only option is to utilize that coverage.

b) If there is no other coverage option for the child the CHAND subscriber will be asked if she wants the newborn covered under her policy for the first 31 days of life.

- Any claims, deductibles and coinsurance amounts incurred for the newborn through the Mother's policy are accumulated toward the Mother's lifetime maximum and annual out of pocket maximum.
- Waiting periods do not apply.
- CHAND will not pay as a secondary payer under the mother's policy during the first 31 days if other coverage is available.

A Newly born child may not be added to the father's policy.

Traditional Plan Only

A child that will remain on CHAND after the 31 days of coverage through the mother's policy may move to a Traditional Plan policy of his/her own by completing a Traditional plan application and provide the appropriate premium within the 31 days following birth.

- The dollars paid under the mother's CHAND plan will not be moved to the newborn's accumulator.
- Waiting periods do not apply.
- A newborn will not be required to submit a certification of eligibility.

A newborn or child, who meets the eligibility requirements for a Traditional Plan and has not been covered through the mother's CHAND policy, may apply for coverage through CHAND.

- Effective Date will be the date of signature.
- CHAND will always be the payer of last resort.
- Waiting periods will apply.

Other Coverage

	CHAND is the payer of last resort.	An individual may <u>not</u> be enrolled in Medicaid and CHAND at the same time.	An individual may only have one CHAND policy.	CHAND subscriber may have additional health insurance coverage, other than Medicaid.	CHAND subscriber may have coverage with a limited benefit for a specific condition, other than Medicaid.	CHAND subscriber may have Medicare A & B coverage due to age or disability.	A newborn can be covered under its mother's plan for the first 31 days if the newborn is not eligible to be added to a different insurance plan.	CHAND Traditional subscriber may have Medicare A & B and a Medicare Supplement plan with a commercial carrier.	CHAND subscriber may have Medicare A & B and a major medical plan with a commercial carrier.
Traditional –Dependent or Spouse	X	X	X	X	X	X	X	X	
Traditional – Rejection or Refusal	X	X	X	X	X	X	X	X	
Traditional – Restrictive Rider or PE	X	X	X	X	X	X	X	X	
Traditional – Rate exceeds CHAND	X	X	X	X	X	X	X	X	
Traditional – Medical Condition	X	X	X	X	X	X	X	X	
Traditional – Lifetime Maximum Met	X	X	X	X	X	X	X	X	
HIPAA	X	X	X				X		
TAARA	X	X	X				X		
Supplement –Dependent or Spouse	X	X	X	X	X	X			X
Supplement – Rejection or Refusal	X	X	X	X	X	X			X
Supplement – Restrictive Rider or PE	X	X	X	X	X	X			X
Supplement – Rate exceeds CHAND	X	X	X	X	X	X			X
Supplement – Medical Condition	X	X	X	X	X	X			X

Preexisting Conditions and Waiting Periods

HIPAA and TAARA Applicants

HIPAA and TAARA individuals are exempt from preexisting condition limitations and waiting period restrictions.

Traditional and Age 65 and Over or Disabled Applicants

A waiting period of 180 consecutive days beginning on the [effective date](#) of this benefit plan must be fulfilled before benefits will be available for any services, supplies or charges for the treatment of any condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 180 days immediately preceding the [signature date](#) of application.

- A waiting period of 270 consecutive days beginning on the [effective date](#) of this benefit plan must be fulfilled before benefits will be available for maternity services. **EXCEPTION:** The waiting period of a subscriber who qualifies for coverage due to a catastrophic condition or major illness who is also pregnant at the time of application for coverage will be eligible for maternity benefit after completing a waiting period of 180 consecutive date beginning on the [effective date](#) of this benefit plan.

The waiting period does not apply to nonelective treatment or procedures for a congenital conditions or genetic diseases.

The waiting period does not apply to an applicant who has obtained coverage due to reaching the lifetime maximum coverage amount on his/her most recent health insurance coverage. **NOTE:** This exception is applies only to Traditional Applicants.

Waiting Periods are not applied to a newly born child moving from the mother's CHAND coverage.

- Waiting Periods are applied to a newborn or child entering CHAND without first being covered through the mother's CHAND coverage.

Waiting Periods are applied to the spouse of an individual who is enrolled in CHAND.

Waiting Periods are applied to a dependent of an individual who is enrolled in CHAND.

A reduction in waiting period days by the aggregate period of qualifying previous coverage to the extent made available by the previous coverage is allowed provided the CHAND application was signed and the [effective date](#) is within 63 days of termination of the qualifying previous coverage and a significant break (63 days or more) in the previous coverage has not occurred.

Preexisting Conditions and Waiting Periods

Exemption Requests and Appeals

The CHAND Board of Directors, by a two-thirds majority vote, can exempt an applicant from the waiting period and preexisting condition provisions when “required under emergency circumstances to allow the applicant access to medical procedures determined to be necessary to preserve life”.

- The Lead Carrier’s CHAND Administrator coordinates waiver of waiting period requests based on the approved policy for this process. Requests are reviewed by a committee of Lead Carrier personnel prior to research and consultation with the Commissioner of Insurance. If it is determined that the individual has been refused medical services or treatment in addition to requiring an emergency life saving service, an emergency meeting of the Board of Directors will be called.
- A medical facility or provider requiring an individual to make payment arrangements prior to receiving services is not a refusal to provide treatment.

Preexisting Conditions and Waiting Periods Grid

Applicable waiting periods and preexisting limitations vary by CHAND product. ("X" indicates waiting periods and preexisting conditions by plan.)	Exempt from preexisting condition limitations and waiting period restrictions.	180 day waiting period from effective date for services, supplies or charges for the treatment of any condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 180 days immediately preceding the signature date of the application.	Exemption for nonelective treatment for congenital conditions or genetic diseases.	270 day waiting period from effective date of this benefit plan for maternity services. Reduction of 270 day maternity waiting period to 180 days if the subscriber qualified for CHAND due to a catastrophic condition or major illness at the time of application.	Exemption of waiting period for a newly born child moving from the mother's CHAND coverage.	180 day waiting period applies to a newborn or child entering CHAND without first being covered through the mother's CHAND coverage.	Reduction in waiting period days by the aggregate period of qualifying previous coverage to the extent made available by the previous coverage provided the CHAND application is signed and the effective date is within 63 days of termination of the qualifying previous coverage and a significant break (more than 63 days) in the qualifying previous coverage has NOT occurred.
Traditional –Dependent or Spouse		X	X	X	X	X	X
Traditional – Rejection or Refusal		X	X	X	X	X	X
Traditional – Restrictive Rider or PE		X	X	X	X	X	X
Traditional – Rate exceeds CHAND		X	X	X	X	X	X
Traditional – Medical Condition		X	X	X	X	X	X
Traditional – Lifetime Maximum Met	X						
HIPAA	X						
TAARA	X						
Supplement –Dependent or Spouse		X	X	X		X	X
Supplement – Rejection or Refusal		X	X	X		X	X
Supplement – Restrictive Rider or PE		X	X	X		X	X
Supplement – Rate exceeds CHAND		X	X	X		X	X
Supplement – Medical Condition		X	X	X		X	X
EXEMPTION TO: WAITING PERIODS AND PREEXISTING CONDITIONS Applicable exemptions vary by CHAND product. ("X" indicates plans that may be eligible for exemptions.)			<p>CHAND Board can exempt an applicant from the waiting period and preexisting condition provision when required under emergency circumstances to allow the applicant access to medical procedures determined to be necessary to preserve life."</p> <p>NOTE: A written request is required and should be mailed to the CHAND Administrator.</p>				
Traditional and Age 65 and Over or Disabled – Dependent or Spouse			X				
Traditional and Age 65 and Over or Disabled – Rejection or Refusal			X				
Traditional and Age 65 and Over or Disabled – Restrictive Rider or PE			X				
Traditional and Age 65 and Over or Disabled – Rate exceeds CHAND			X				
Traditional and Age 65 and Over or Disabled – Medical Condition			X				

Preexisting Condition Insurance Plan - PCIP

Federal Plan

PCIP is the Preexisting Condition Insurance Plan

- The U.S. Department of Health and Human Services runs the PCIP for North Dakota.
- Agents and other vendors are not allowed to sell these products.
- If an individual has been uninsured for at least six months this may be an option.
- The website is www.PCIP.gov or 1-866-717-5826

Premiums - Payment

All Applicants

Premiums that are submitted with applications should be in the form of a personal check or money order. The premium will be held until the application is accepted or denied.

Premium must accompany application to process correctly.

An individual who owes premium to CHAND may not reapply to CHAND until the past premium has been paid.

Premiums paid from a trust account in the subscriber's name will be accepted.

Premiums paid from an Individual Indian Money account will be accepted.

Traditional – Age 65 & Over or Disabled - HIPAA

Premium payments may be made through electronic funds transfer (EFT Banking) or subscribers may choose to be billed directly.

Premiums may be paid on a monthly, quarterly, semi-annually, or yearly basis.

HIPAA

An individual who has had prior coverage terminated for nonpayment of premiums or fraud is not eligible to enroll as a HIPAA applicant.

TAARA

Premium payments may be made through the payment-processing center established under the Federal Trade Adjustment Assistance Reform Act of 2002.

Subscribers can also use electronic funds transfer (EFT Banking) or choose to be billed directly and be reimbursed from the federal program.

Premiums – Third Party Payment or Reimbursement

All Applicants

NOTE:

- Government-sponsored program, government agency, health care provider, nonprofit charitable organization or employer includes but is not limited to: pharmaceutical companies, Medicaid, Indian Health Services, and disease specific entities.

	Premium payment may not be made by a government-sponsored program, government agency, health care provider, nonprofit charitable organization or employer.	Premium may be paid for or reimbursed through a program established under the Federal Trade Adjustment Assistance Reform Act of 2002. They can be made through electronic funds transfer (EFT banking) or subscribers may be billed directly and be reimbursed from the federal government.	Premium may be paid from an Individual Indian Money Account (IIM), which is established from the use or sale of a trust asset which is placed in an account.	Premiums may be paid from a trust account in the subscriber's name.
Traditional –Dependent or Spouse	X		X	X
Traditional – Rejection or Refusal	X		X	X
Traditional – Restrictive Rider or PE	X		X	X
Traditional – Rate exceeds CHAND	X		X	X
Traditional – Medical Condition	X		X	X
Traditional – Lifetime Maximum Met	X		X	X
HIPAA	X		X	X
TAARA	X	X	X	X
Supplement –Dependent or Spouse	X		X	X
Supplement – Rejection or Refusal	X		X	X
Supplement – Restrictive Rider or PE	X		X	X
Supplement – Rate exceeds CHAND	X		X	X
Supplement – Medical Condition	X		X	X

Premiums – Owner Paid Premiums

HIPAA and TAARA

There are no exceptions to employer paid premium guidelines for HIPAA and TAARA subscribers due to eligibility requirements.

Traditional – Age 65 & Over or Disabled

CHAND may accept premiums from an owner/president if the owner/president is **NOT** paying premium for other employees **AND** the CHAND premium is for:

- his/her CHAND premium; or
- his/her and his/her spouse's or any minor or dependent adult child(ren)'s (including those stipulated through a court order such as ex-spouse's or any minor child(ren)'s) CHAND premium if the spouse and/or dependent is not also considered to be an employee (receives compensation or a W-2, 1099, etc.).
- Verification of the business premium will be noted on SMLALL

CHAND may **NOT** accept premiums from an owner/president for any of the above described circumstances or a specific employee if the owner/president is purchasing other insurance coverage for other employees.

CHAND may accept premium for one co-owner of a business under the circumstances outlined above.

- Verification of business premium will be noted on SMLALL.
- Additional co-owners will need to provide verification that they are NOT employees (receives compensation or a W-2, 1099, etc.).

NOTE:

IF second co-owner exists, Marketing should be contacted to ensure the co-owners have been offered a small group product as **this would be a small employer group under Chapter 26.1-36.3 and CHAND coverage could not be issued to an employee of the group.**

Prior CHAND Coverage

Traditional – Age 65 & Over or Disabled - TAARA

An individual who has previously terminated his/her CHAND coverage is not eligible to apply for coverage through CHAND unless twelve months have passed since the last termination of CHAND coverage.

- This provision does not apply to an individual who has maintained continuous CHAND coverage and is moving between CHAND plans.
- A CHAND enrollee who terminates CHAND coverage to enroll in a Medicare Advantage plan may be allowed to re-apply to CHAND within 12 months of switching to a Medicare Advantage plan. The 12-month break in CHAND coverage does not apply in this situation.

An individual who owes premium to CHAND may not reapply to CHAND until the past premium has been paid.

HIPAA

A minimum lapse between termination and re-application is not applied to HIPAA applicants.

- To reapply for CHAND as a HIPAA subscriber, the lapse may not exceed 63 days.
- All other applicable HIPAA requirements apply.

An individual who has had prior coverage terminated for nonpayment of premiums or fraud is not eligible to enroll as a HIPAA applicant.

Prior Termination for Nonpayment of Health Insurance Premiums

Traditional – Age 65 & Over or Disabled - TAARA

An individual who owes premium to CHAND may not reapply to CHAND until the past premium has been paid.

HIPAA

An individual who has had prior coverage terminated for nonpayment of premiums or fraud is not eligible to enroll as a HIPAA applicant.

Residency - Requirements

NDCC 54-01-26

Residence - Rules for determining. Every person has in law a residence. In determining the place of residence, the following rules must be observed:

1. It is the place where one remains when not called elsewhere for labor or other special or temporary purpose and to which the person returns in seasons of repose.
2. There can be only one residence.
3. A residence cannot be lost until another is gained.
4. The residence of the supporting parent during the supporting parent's life, and after the supporting parent's death, the residence of the other parent is the residence of the unmarried minor children.
5. An individual's residence does not automatically change upon marriage, but changes in accordance with subsection 7. The residence of either party to a marriage is not presumptive evidence of the other party's residence.
6. The residence of an unmarried minor who has a parent living cannot be changed by either that minor's own act or that of that minor's guardian.
7. The residence can be changed only by the union of act and intent.

Traditional – Age 65 & Over or Disabled - TAARA

Requires that an applicant is currently a legal resident of ND and has been a resident of the state for at least 183 days prior to application. (Reference NDCC 54-01-26.)

HIPAA

Requires that an applicant currently is a legal resident of ND. The minimum length of residency requirement does not apply.

Residency - Exceptions

All Applicants

An individual may purchase coverage through CHAND until they are eligible to obtain residency in a new state (up to the residency requirement of the new state) as all individuals must be a resident of some state. As long as they are not able to be a resident of a different state, they are technically ND residents and therefore remain eligible for CHAND.

The board may waive the residency requirement upon a showing of good cause.

Minor or Dependent Children – Provided the following can be verified, the minor or dependent child may remain on CHAND:

- 1) The parents or guardians are North Dakota residents and remain North Dakota residents;
- 2) The CHAND subscriber is a North Dakota resident and remains a North Dakota resident;
- 3) The CHAND subscriber is out of state on a temporary basis and intends to return to North Dakota;
- 4) The parents, guardians and/or CHAND subscriber have taken no steps to acquire residence in another state, such as voting in the other state or claiming residency for the purpose of obtaining in-state tuition, etc.; and in addition,
- 5) The CHAND subscriber is a minor or dependent:
 - a) whose parent or guardian is transferred out of state on a temporary basis for a job or assignment;
 - b) whose parent or guardian is called to military duty so the CHAND subscriber is placed out of state;
 - c) who is placed with a guardian who lives out of state for an undetermined period of time; or,
 - d) who is attending college out of state for nine months out of a year.

Other - Provided the following can be verified, the individual may remain on CHAND:

- 1) The CHAND subscriber is out of state on a temporary basis and intends to return to ND;
- 2) The CHAND subscriber has taken no steps to acquire residence in another state, such as voting in the other state or claiming residency for the purpose of obtaining in-state tuition, etc.; and in addition,
- 3) The CHAND subscriber:
 - a) is no longer able to live independently due to medical reasons and moves out of state to live with a relative for an undetermined time;
 - b) has a medical condition and is living out of state for treatment;
 - c) lives out of state during the winter months; or,
 - d) lives out of state but maintains a residence in ND.

Review and Processing of Applications

All Applicants

CHAND applications must either be rejected for failing to comply with the necessary requirements or accepted for coverage within 30 days of receipt of the application with notice of acceptance or denial provided to the individual.

HIPAA Applicants - Additional

If the application is submitted with the premium and the first page completed, but the applicant fails to complete the second page or does not provide any type of evidence of eligibility, the application is not considered complete.

- The Lead carrier will contact the applicant to request some type of acceptable evidence.
- The 63-day HIPAA time period will stop upon receipt by the Lead Carrier but the application will not be processed until this evidence is received.
- If the applicant provides the information to the Lead Carrier prior to 30 days from receipt of the application, the Lead Carrier will process the application and if approved, honor the original application dates.
- If the applicant does NOT provide the information to the Lead Carrier prior to 30 days from receipt of the application, the Lead Carrier will disapprove the application and refund the premium.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.

If an application is submitted with the premium and the first and second pages are completed, but the applicant fails to provide some type of evidence of eligibility, the application will be accepted if it provides enough information for the Lead Carrier to verify the applicant's eligibility.

- The 63-day HIPAA time period will stop upon receipt by the Lead Carrier.
- Verification of eligibility may require the Lead Carrier to telephonically contact the applicant's former insurer or employer to verify previous coverage.
- If the applicant provides the information within the timeframe, the Lead Carrier will process the application and if approved, honor the original application dates.
- If the applicant does NOT provide the information within the timeframe, the Lead Carrier will disapprove the application and refund the premium.
- The reason for disapproval will be provided to the applicant and/or agent in writing.
- The applicant will need to provide a new application.

Spouses

Traditional, Age 65 & Over or Disabled, or HIPAA

Any North Dakota [resident](#) who is the spouse of an individual who is enrolled with CHAND Traditional, Age 65 & Over or Disabled, or HIPAA coverage is also eligible for CHAND coverage.

- The spouse will need to complete a separate **Traditional** application and provide appropriate premium.
- A 180-day waiting period will apply unless a certificate of creditable coverage can be provided.
- A representative from the Lead Carrier will complete confirmation of eligibility.
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TAARA

Any North Dakota [resident](#) who is the spouse of a CHAND individual is also eligible for CHAND coverage.

- The spouse will need to be named on the HCTC Eligibility Certificate (Letter #L3779 Revised 2-2010) provided by Health Care Tax Credit.
- The spouse will need to complete a separate **TAARA** application and provide appropriate premium.
- A representative of the Lead Carrier will complete confirmation of [eligibility](#) as determined by Health Care Tax Credit certification.

Termination Guidelines

Coverage terminates at the end of the month for which the necessary premiums have been paid if the Subscriber:	Traditional	Age 65 & Over or Disabled	HIPAA	TAARA
Becomes enrolled in health benefits with the state's medical assistance (Medicaid).	Yes.	Yes.	Yes.	Yes.
Is no longer a legal resident of the state, except a subscriber who is absent for a verifiable medical or other reason as determined by the Board.	Yes.	Yes.	Yes.	Yes.
Fails to respond to an inquiry from the Lead Carrier regarding eligibility or residency within 31 days from the inquiry date.	Yes.	Yes.	Yes.	Yes.
Is imprisoned under federal, state, or local authority.	Yes.	Yes.	No.	Yes.
Has premiums paid for or reimbursed under any government sponsored program, government agency, health care provider, nonprofit charitable organization or employer.	Yes.	Yes.	Yes.	Yes. Unless HCTC
Coverage will terminate with a written request from the subscriber:	Traditional	Age 65 & Over or Disabled	HIPAA	TAARA
Coverage will be cancelled at the end of the month for which premiums have been paid.	Yes.	Yes.	Yes.	Yes.
Coverage will be terminated on any date during a given month:	Traditional	Age 65 & Over or Disabled	HIPAA	TAARA
If this occurs prior to the 16 th of the month, one-half months premiums will be refunded.	Yes.	Yes.	Yes.	Yes.
<ul style="list-style-type: none"> • When benefits paid to an individual reach the lifetime maximum of \$1,000,000. • Due to death. • Due to divorce. • Transferring to other coverage. 	Yes.	Yes.	Yes.	Yes.
Coverage will be terminated at the end of the month of the 31-day grace period if:	Traditional	Age 65 & Over or Disabled	HIPAA	TAARA
The subscriber fails to pay the require premium. However, upon proof of concurrent coverage, the CHAND plan will be cancelled back to the end of the month for which premiums have been paid. Paid CHAND claims will be reprocessed as denied and submitted to the concurrent insurance carrier.	Yes.	Yes.	Yes.	Yes.

Time Limitations to Apply

Traditional and Age 65 and Over or Disabled

An individual may apply for CHAND coverage at any time by meeting [eligibility requirements](#).

An individual is not required to have prior coverage to be eligible for CHAND coverage, however if the application is made within 63 days of termination of qualifying previous coverage, the applicant may be eligible to reduce waiting period days.

HIPAA

An individual with qualifying previous coverage who meets the eligibility requirements may apply if application is made less than 64 days following termination of qualifying previous coverage.

The individuals must have had at least 18 months of qualifying previous coverage:

- 1) group health benefit plan;
- 2) health benefit plan;
- 3) Medicare;
- 4) Medicaid;
- 5) TRICARE;
- 6) Indian Health Services;
- 7) state risk pool coverage;
- 8) health plan under §5 U.S.C. 89;
- 9) public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government or a foreign government;
- 10) health benefit plan §5(e) of the Peace Corps Act; and,
- 11) state children's health insurance.

TAARA

An individual who meets the eligibility requirements may apply if application is made less than 64 days following termination of qualifying coverage.

The individual must have had at least three (3) months of previous health insurance coverage at the time of application.