Questions, answers and information about Medicare supplement insurance:

Q. Why do I need Basic Supplement insurance?

A. Medicare does not pay for everything. Basic Supplement insurance is designed to help pay for some of the charges the Medicare program does not. The Comprehensive Health Association of North Dakota (CHAND) has two supplement plans to choose from. The information in this brochure is about the Basic Supplement.

Q. What is Basic Supplement coverage?

A. The Basic Supplement is the most basic of the supplement plans offered. The Basic Supplement provides for basic coverage of Medicare approved services including the hospital benefits coinsurance, plus coverage for 365 additional days in the hospital after Medicare benefits end. The 20% coinsurance for Medicare approved physician benefits is also covered.

Waiting periods

There is a waiting period of 180 consecutive days beginning on the effective date of this benefit plan that 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. The waiting period does not apply to nonelective treatment or procedures for congenital or genetic diseases.

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: 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 benefits after completing a waiting period of 180 consecutive days of coverage.

The waiting period may be reduced by qualifying previous coverage, if the signature date of application and the effective date of your benefit plan are no more than 63 days following termination of previous coverage.

The CHAND Board of Directors, by a two-thirds majority vote, may exempt a subscriber from the provisions of the waiting periods when required under emergency circumstances to allow the applicant access to medical procedures determined to be necessary to preserve life.

Glossary

Benefit period
A benefit period begins on the first day you enter a hospital or skilled nursing facility as a Medicare patient and ends 60 consecutive days after you are discharged. A new benefit period begins when 60 days without a hospital or skilled nursing facility stay have elapsed.

Calendar year
Each calendar year begins on January 1 and ends on December 31 of that year.

Covered services
This term refers to covered services or supplies specified in your benefit plan for which benefits will be provided.

Medicare coinsurance
A part of the charge for your hospital or medical care which Medicare does not pay.

Medicare copayment amount
A predetermined dollar amount established by Medicare under a prospective payment system for some outpatient hospital services that Medicare does not pay.

Medicare deductible
A specified dollar amount of Medicare eligible expenses that you are responsible for paying before Medicare will begin making payments for covered services.

Medicare eligible expenses
Health care expenses that are covered services under Medicare Part A or Part B that are recognized as reasonable and medically necessary by Medicare.

Preexisting condition
A condition, disease, illness or injury for which you receive medical advice or treatment within the 180-day period immediately preceding the date of application under your benefit plan.

Further facts on coverage, rates and enrollment are available from:

Fargo Office
4510 13th Ave. S.
Telephone: 277-2232

Bismarck Office
1415 Mapleton Ave.
Telephone: 223-6348

Grand Forks Office
3570 S. 42nd St.,
Suite B
Telephone: 795-5340

Minot Office
1308 20th Ave. SW.
Telephone: 858-5000

Jamestown Office
300 2nd Ave. NE,
Suite 132
Telephone: 251-3180

Williston Office
1500 14th Street West,
Suite 270
Telephone: 572-4535

Call Toll-Free: (844) 363-8457

www.CHAND.org

This brochure presents a brief explanation of the covered services and payment levels of this product. It should not be used to determine whether your health care expenses will be paid. The written benefit plan between you and CHAND governs what benefits are available.

Lead Carrier Service by:

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CHAND
Comprehensive Health Association of North Dakota

Basic Supplement

for Individuals age 65 and older or with disabilities who are eligible for Medicare

Medicare and Basic Supplement Benefits and Coverages – 2025

Medicare (Part A) Hospital Services Per Calendar Year

Services	Medicare Pays	Basic Supplement Pays	You Pay
Hospitalization* – Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676.50	$0	$1,676.50 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* – You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care – You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment / coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

These are some items not covered:

- Services that are experimental or investigative in nature or that are not medically necessary as determined by Medicare.
- Services received prior to the effective date of your benefit plan.
- Services that are applicable to Medicare deductible amounts.
- Services when benefits are provided by any governmental unit or social agency except Medicaid or when payment has been made under Medicare Part A or Part B.
- Outpatient prescription drugs, unless eligible under Medicare.
- Custodial care provided in a hospital or by a home health agency.
- Skilled nursing facility care costs beyond what is covered by Medicare, including swing bed services in a hospital.
- Surgery to improve appearance

Medicare (Part B) Medical Services Per Calendar Year

Services	Medicare Pays	Basic Supplement Pays	You Pay
Medical Expenses – In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
Blood			
First three pints	$0	All costs	$0
Next $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services			
	100%	$0	$0

Parts A and B

Services	Medicare Pays	Basic Supplement Pays	You Pay
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-approved amounts***	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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

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

***Once you have been billed $257 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

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