# CHAPTER 26.1-08
# COMPREHENSIVE HEALTH ASSOCIATION

**26.1-08-01. Definitions.**

In this chapter, unless the context otherwise requires:

1. "Association" means the comprehensive health association of North Dakota.
2. "Benefit plan" means insurance policy coverage offered by the association through the lead carrier.
3. "Benefit plan premium" means the charge for the benefit plan based on the benefits provided in section 26.1-08-06 and determined pursuant to section 26.1-08-08.
4. "Board" means the association board of directors.
5. "Church plan" means a plan as defined under section 3(33) of the federal Employee Retirement Income Security Act of 1974.
6. "Creditable coverage" has the same meaning as "qualifying previous coverage" as defined under section 26.1-36.3-01.
7. "Eligible individual" means an individual eligible for association benefit plan coverage as specified under section 26.1-08-12.
8. "Governmental plan" has the same meaning as provided under section 3(32) of the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 833; 29 U.S.C. 1002] and as may be provided under any federal governmental plan.
9. "Group health plan" has the same meaning as employee welfare benefit plan as provided under section 3(1) of the federal Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 833; 29 U.S.C. 1002] to the extent that the plan provides medical care, and including items and service paid for as medical care to employees or the employees' dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
10. "Health insurance coverage" means any hospital and medical expense-incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible individual, chiropractic care.
    a. Health insurance coverage does not include any one or more of the following:
        (1) Coverage only for accident, disability income insurance, or any combination of the two;
        (2) Coverage issued as a supplement to liability insurance;
        (3) Liability insurance, including general liability insurance and automobile liability insurance;
        (4) Workforce safety and insurance or similar insurance;
        (5) Automobile medical payment insurance;
        (6) Credit-only insurance;
        (7) Coverage for onsite medical clinics; and
        (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
    b. Health insurance coverage does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:
        (1) Limited scope dental or vision benefits;
        (2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of this care; and
        (3) Other similar limited benefits specified under federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].
    c. Health insurance coverage does not include any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; any exclusion of

benefits under any group health insurance coverage maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

(1) Coverage only for specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

d. Health insurance coverage does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(2) Similar supplemental coverage provided under a group health plan.

11. "Insurer" means any insurance company, nonprofit health service organization, fraternal benefit society, health maintenance organization, and any other entity providing or selling health insurance coverage or health benefits that are subject to state insurance regulation.
12. "Lead carrier" means the insurance company selected by the board to administer the association benefit plans.
13. "Medicare" means coverage under both parts A and B of title XVIII of the federal Social Security Act [Pub. L. 89-97; 79 Stat. 291; 42 U.S.C. 1395 et seq.].
14. "Participating member" means any insurer that is licensed in this state which has an annual earned premium volume of health insurance coverage, including Medicare supplemental health insurances as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 1395ss(g)(1)], derived from or on behalf of residents in the previous calendar year of at least one hundred thousand dollars.
15. "Resident" means an individual who has been a legal resident of this state for a minimum of one hundred eighty-three days, determined by applying section 54-01-26. However, for a federally defined eligible individual as defined under subdivision b of subsection 5 of section 26.1-08-12, there is no minimum residency requirement. The board may waive the residency requirement upon a showing of good cause.
16. "Significant break in coverage" means a period of sixty-three or more consecutive days during all of which the individual does not have creditable coverage. Neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.
17. "Trade adjustment assistance, pension benefit guarantee corporation individual" means an individual who is certified as eligible for federal trade adjustment assistance or federal pension benefit guarantee corporation assistance as provided by the federal Trade Adjustment Assistance Reform Act of 2002 [Pub. L. 107-210; 116 Stat. 933], the spouse of such an individual, or a dependent of such an individual as provided under the federal Internal Revenue Code.

**26.1-08-02. Duties of commissioner.**

Repealed by S.L. 2003, ch. 239, § 18.

**26.1-08-02.1. Board of directors.**

1. The board consists of the commissioner; the state health officer; the director of the office of management and budget; one senator appointed by the majority leader of the senate of the legislative assembly; one representative appointed by the speaker of the house of representatives of the legislative assembly; and one individual from each of the three participating member insurance companies of the association with the highest annual premium volumes of health insurance coverage as provided by the commissioner, verified by the lead carrier, and approved by the board.
2. Members of the board may be reimbursed from the moneys of the association for expenses incurred by the members due to their service as board members, but may not otherwise be compensated by the association for board services.

3. The costs of conducting the meetings of the association and the board are borne by the association.
4. The commissioner shall fill vacancies and, for cause, may remove any board member representing one of the three participating member insurance companies.

**26.1-08-02.2. Powers and duties of commissioner and board - Fees.**

1. The lead carrier shall operate the association subject to the supervision and control of the board.
2. The board shall:
   a. Formulate general policies to advance the purposes of this chapter;
   b. Approve the association's contract with the lead carrier;
   c. Approve the benefit plans;
   d. Approve the benefit plan premiums;
   e. Establish and modify from time to time, as appropriate, agents' referral fees;
   f. Approve the annual operating budget and any assessments to the participating members;
   g. Approve independent annual audits to assure the general accuracy of the financial data submitted by the lead carrier for the association;
   h. Develop and implement a program to publicize the existence of the association, the eligibility requirements, and procedures for enrollment and to maintain public awareness of the association;
   i. Approve bylaws and operating rules;
   j. Exempt, by a two-thirds majority vote, an applicant from the pre-existing condition provisions of subsection 13 of section 26.1-08-12 when required under emergency circumstances to allow the applicant access to medical procedures determined to be necessary to preserve life; and
   k. Provide for other matters as may be necessary and proper for the execution of the commissioner's and board's powers, duties, and obligations.
3. The commissioner, board, and lead carrier employees are not liable for any obligations of the association.
4. The commissioner may establish additional powers and duties of the board and may adopt rules necessary and proper for the association and to implement this chapter.

**26.1-08-03. Comprehensive health association.**

Repealed by S.L. 2003, ch. 239, § 18.

**26.1-08-03.1. Operation of the association.**

The association may:

1. Exercise the powers granted to insurance companies under the laws of this state.
2. Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessment due the association.
3. Take such legal action as necessary:
   a. To avoid the payment of improper claims against the association or the coverage provided by or through the association;
   b. To recover any amounts erroneously or improperly paid by the association;
   c. To recover any amounts paid by the association as a result of mistake of fact or law; or
   d. To recover other amounts due the association.
4. Enter contracts with the insurance companies, similar associations in other states, or other persons for the performance of administrative functions.
5. Establish administrative and accounting procedures for the operation of the association.
6. Provide for the reinsuring of risks incurred as a result of issuing the coverages required by individuals covered by the association benefit plans.

7. Provide for the administration by the association of policies, which are reinsured pursuant to subsection 6.
8. Issue benefit plans for coverage in accordance with the requirements of sections 26.1-08-06 and 26.1-08-06.1.
9. Design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

**26.1-08-04. Association plan.**
Repealed by S.L. 2003, ch. 239, § 18.

**26.1-08-05. Minimum benefits of a qualified plan A.**
Repealed by S.L. 1997, ch. 251, § 18.

**26.1-08-06. Comprehensive benefit plan.**
1. The benefit plan must offer comprehensive health care coverage to every eligible individual. The coverage to be issued by the association, its schedule of benefits, exclusions, and other limitations must be established by the lead carrier and subject to the approval of the board.
2. In establishing the benefit plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate. Benefit levels, deductibles, coinsurance factors, copayments, exclusions, and limitations may be applied as determined to be generally reflective of health insurance coverage provided in the state.
3. The coverage may include deductibles of not less than five hundred dollars per individual per benefit period.
4. The coverage must include a limitation of not less than three thousand dollars per individual on the total annual out-of-pocket expenses for services covered under this section.
5. Any coverage or combination of coverages through the association may not exceed a lifetime maximum benefit of one million dollars for an individual.
6. The coverage may include cost-containment measures and requirements, including preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost-effective.
7. The coverage may include preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.
8. Coverage must include oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.
9. Coverage must include substance abuse and mental disorders as outlined in sections 26.1-36-08 and 26.1-36-09.
10. Covered expenses must include, at the option of the eligible individual, professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.
11. The coverage must include organ transplants as approved by the board.
12. The association must be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under an association benefit plan must be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workforce safety and insurance coverage, automobile medical payment or liability insurance whether provided on the basis of fault or no fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program. The association must have a cause of action against

an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this subsection.

**26.1-08-06.1. Age sixty-five and over and disabled supplement plans.**

A basic supplement plan and standard supplemental plan must be offered to individuals who are eligible for Medicare by reason of age or disability. Supplemental plans issued by the association must be developed by the lead carrier and approved by the board. Any coverage or combination of coverages through the association may not exceed a maximum benefit of one million dollars for an individual.

**26.1-08-07. Approval and filing of benefit plans.**

The lead carrier shall file with the commissioner all benefit plans and other forms required to be approved. The commissioner shall approve or disapprove any form within sixty days of receipt.

**26.1-08-08. Benefit plan premium.**

The schedule of premiums to be charged eligible individuals for a benefit plan must be established by the lead carrier and approved by the board, but may not exceed one hundred thirty-five percent of the individual premium rates charged for similar coverage throughout the state. If similar coverage is not offered by other insurance carriers, premium rates for actuarial equivalent benefit plans offered by other insurers in the state must be provided by the commissioner and utilized by the lead carrier to determine association rates for the benefit plans.

**26.1-08-09. Participating members.**

1. There is established a comprehensive health association with participating members.
2. All participating members shall maintain their membership in the association, as a condition for writing policies in this state.
3. Each participating member of the association shall share the losses due to claims and administrative expenses of the association. The difference between the total claims expense of the association and the benefit plan premiums received is the liability of the participating members. Such participating members shall share in the excess costs of the association in an amount equal to the ratio of a participating member's total annual premium volume for health insurance received from or on behalf of state residents, to the total health insurance premium volume received by all of the participating members as determined by the lead carrier and approved by the board. For determining the liability of participating members, health insurance coverage includes Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 1395ss(g)(1)] but does not include federal employees health benefits plans or Medicare part C plans.
4. Each member's liability may be determined retroactively and payment of the assessment is due within thirty days after notice of the assessment is given. Failure by a member to tender to the lead carrier on behalf of the association the full amount assessed within thirty days of notification by the lead carrier is grounds for termination of membership.

**26.1-08-10. Administration of the association.**

1. Not less than eighty-seven and one-half percent of the association plan premium paid to the lead carrier may be used to pay claims.
2. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association or be allocated to reduce benefit plan premiums.

3. The lead carrier agreement must continue for a period of at least three years, unless a request to terminate is approved by the board. The board shall approve or deny a request to terminate within ninety days of its receipt. A failure to make a final decision on a request to terminate within the specified period is deemed an approval. The agreement will be automatically renewed until either party terminates the agreement.
4. The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses which are assignable to the maintenance and administration of the association. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.
5. The lead carrier is, when carrying out its duties under this chapter, an agent of the association and the board, and is civilly liable for its actions, subject to the laws of this state.
6. The lead carrier shall:
   a. Perform all administrative and claims payment functions required under this chapter.
   b. Determine eligibility of individuals requesting coverage through the association.
   c. Provide all eligible individuals involved in the association an individual certificate setting forth a statement as to the insurance protection to which the individual is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.
   d. Pay all claims under this chapter and indicate that the association paid the claims. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.
   e. Establish a premium billing procedure for collection of premium from individuals covered by the association.
   f. Obtain approval from the board for all benefit plan premiums and benefit plans issued.
   g. Submit regular reports to the board regarding the operation of the association.
   h. Submit to the participating companies and board, on a semiannual basis, a report of the operation of the association.
   i. Verify premium volumes of all health insurers in the state.
   j. Determine and collect assessments.
   k. Perform such functions relating to the association as may be assigned to it.

**26.1-08-11. Solicitation of eligible individuals.**

1. The association, pursuant to a plan approved by the board, shall disseminate appropriate information to the residents of this state regarding the existence of the association, the benefit plans, and the means of enrollment. Means of communication may include use of the press, radio, electronic mail, internet, and television, as well as publication in appropriate state offices and publications.
2. The association and board shall devise and implement means of maintaining public awareness of the association and shall administer this chapter in a manner that facilitates public participation.
3. All licensed accident and health insurance producers may engage in the selling or marketing of association benefit plans. The lead carrier shall pay a referral fee to each licensed accident and health insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid to the lead carrier from moneys received as premiums for the association benefit plan.
4. Every insurance company that rejects or applies underwriting restrictions to an applicant for health insurance shall notify the applicant of the existence of the association, requirements for being accepted in it, and the procedure for applying to it.

**26.1-08-12. Eligibility.**

1. The association must be open for enrollment by eligible individuals. Eligible individuals shall apply for enrollment in the association by submitting an application to the lead carrier. The application must be completed fully and accompanied by premium and evidence to prove eligibility.
2. Within thirty days of receipt of the application, the lead carrier shall either reject the application for failing to comply with the requirements of this section or forward the eligible individual a notice of acceptance and billing information.
3. At the option of the eligible individual, association coverage is effective:
   a. For an eligible individual applying under subsection 10 or 11, on the signature date of the application.
   b. For an eligible individual applying under subparagraph a of paragraph 1 of subdivision a of subsection 5 or under subparagraph a of paragraph 1 of subdivision c of subsection 5:
      (1) On the day following the date shown on the written evidence;
      (2) On the signature date of the application, if it is at least one day and less than one hundred eighty days following the date shown on the written evidence; or
      (3) On any date after the signature date of the application if the date is at least one day and less than one hundred eighty days following the date shown on the written evidence.
   c. For an eligible individual applying under subparagraph b or c of paragraph 1 of subdivision a of subsection 5 or under subparagraph b or c of paragraph 1 of subdivision c of subsection 5:
      (1) On the signature date of the application; or
      (2) On any date after the signature date of the application but less than one hundred eighty days following the date shown on the written evidence.
   d. For an eligible individual applying under subparagraph d of paragraph 1 of subdivision a of subsection 5, on the date the lifetime maximum occurred if the application:
      (1) Is submitted within ninety days after the date that lifetime maximum occurred; and
      (2) Is accompanied with premium for coverage retroactive to the date that lifetime maximum occurred.
   e. For an eligible individual applying under subdivision b or d of subsection 5:
      (1) On the signature date of the application; or
      (2) On any date after the signature date of the application, but less than sixty-four days following termination of previous coverage.
   f. For an eligible individual applying under subsection 6:
      (1) On the signature date of the application; or
      (2) On any date after the signature date of the application, but less than one hundred eighty days following the date shown on the written evidence from a medical professional.
4. An eligible individual may not purchase more than one policy from the association.
5. An individual may qualify to enroll in the association for benefit plan coverage as:
   a. A traditional applicant:
      (1) An individual who has been a resident of this state and continues to be a resident of the state who has received from at least one insurance carrier within one hundred eighty days of the date of application, one of the following:
         (a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.
         (b) Written evidence that a restrictive rider or a pre-existing condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.

(c) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.
(d) Written evidence that the applicant has reached the lifetime maximum coverage amount on the most recent health insurance coverage.

(2) Is not enrolled in health benefits with the state's medical assistance program.

b. A Health Insurance Portability and Accountability Act of 1996 applicant:

(1) An individual who meets the federally defined eligibility guidelines as follows:
(a) Has had eighteen months of qualifying previous coverage as defined in section 26.1-36.3-01;
(b) Has applied for coverage under this chapter within sixty-three days of the termination of the qualifying previous coverage;
(c) Is not eligible for coverage under Medicare or a group health benefit plan as the term is defined in section 26.1-36.3-01;
(d) Does not have any other health insurance coverage;
(e) Has not had the most recent qualifying previous coverage described in subparagraph a terminated for nonpayment of premiums or fraud; and
(f) If offered under the option, has elected continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state program, and that coverage has exhausted.

(2) Is and continues to be a resident of the state.

(3) Is not enrolled in health benefits with the state's medical assistance program.

c. An applicant age sixty-five and over or disabled:

(1) An individual who is eligible for Medicare by reason of age or disability and has been a resident of this state and continues to be a resident of this state who has received from at least one insurance carrier within one hundred eighty days of the date of application, one of the following:
(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.
(b) Written evidence that a restrictive rider or a pre-existing condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.
(c) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.

(2) Is not enrolled in health benefits with the state's medical assistance program.

d. A Trade Adjustment Assistance Reform Act of 2002 applicant:

(1) A trade adjustment assistance, pension benefit guarantee corporation individual applicant who:
(a) Has three or more months of qualifying previous health insurance coverage at the time of application;
(b) Has applied for coverage within sixty-three days of the termination of the individual's previous health insurance coverage;
(c) Is and continues to be a resident of the state;
(d) Is not enrolled in the state's medical assistance program;
(e) Is not imprisoned under federal, state, or local authority; and
(f) Does not have health insurance coverage through:
[1] The applicant's or spouse's employer if the coverage provides for employer contribution of fifty percent or more of the cost of coverage of the spouse, the eligible individual, and the dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan.

[2] A state's children's health insurance program, as defined under section 50-29-01.
[3] A government plan.
[4] Chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care.
[5] Part A or part B of title XVIII of the federal Social Security Act [42 U.S.C. 1395 et seq.] relating to health insurance for the aged and disabled.

(2) Coverage under this subdivision may be provided to an individual who is eligible for health insurance coverage through the federal Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99-272; 100 Stat. 82]; a spouse's employer plan in which the employer contribution is less than fifty percent; or the individual marketplace, including continuation or guaranteed issue, but who elects to obtain coverage under this subdivision.

6. The board and lead carrier shall develop a list of medical or health conditions for which an individual must be eligible for association coverage without applying for health insurance coverage under subdivisions a and c of subsection 5. Individuals with written evidence of the existence or history of any medical or health conditions on the approved list may not be required to provide written evidence of rejection or refusal, a rate that exceeds the association rates, substantially reduced coverage, or the lifetime maximum amount being reached.
7. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or reinsurance coverage with respect to an applicant under subdivisions a and c of subsection 5 is not sufficient evidence to qualify.
8. A traditional applicant, as specified under subdivision a of subsection 5, may have insurance coverage, other than the state's medical assistance program, with an additional commercial insurer; however, the association will reimburse eligible claim costs as payer of last resort.
9. An individual who is eligible for association coverage as specified under subdivision c of subsection 5 may not have more than one policy that is a supplement to part A or part B of Medicare relating to health insurance for the aged and disabled. The individual may obtain association coverage as a traditional applicant as specified under subdivision a of subsection 5 which is concurrent with a supplement policy offered by a commercial carrier. However, the association will reimburse eligible claims as payer of last resort.
10. If an individual is enrolled in association coverage, that individual's resident dependent is also eligible for association coverage.
11. If an individual is enrolled in association coverage, that individual's resident spouse is also eligible for association coverage.
12. A newly born child without health insurance coverage is covered through the mother's association benefit plan for the first thirty-one days following birth. Continued coverage through the association for the child will be provided if the association receives an application and the appropriate premium within thirty-one days following the birth. This coverage is not available to an applicant under subdivision c of subsection 5.
13. Pre-existing conditions.
    a. Association coverage must exclude charges or expenses incurred during the first one hundred eighty days following the effective date of coverage for any condition for which medical advice, diagnosis, care, or treatment was recommended or received during the one hundred eighty days immediately preceding the signature date of the application.
    b. Association coverage must exclude charges or expenses incurred for maternity during the first two hundred seventy days following the effective date of coverage.
    c. Any individual with coverage through the association due to a catastrophic condition or major illness who is also pregnant at the time of application is eligible for maternity benefits after the first one hundred eighty days of coverage.

d. A pre-existing condition may not be imposed on an individual who is eligible under subparagraph d of paragraph 1 of subdivision a of subsection 5 or subdivision b or d of subsection 5.

14. Waiting periods do not apply:
    a. To nonelective treatment or procedures for a congenital or genetic disease.
    b. To an individual who has obtained coverage as a federally eligible individual as defined in subdivision b of subsection 5.
    c. To an individual who has obtained coverage as an eligible person under subdivision a or c of subsection 5, allowing for a reduction in waiting period days by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06 and provided the association application is made within sixty-three days of termination of the qualifying previous coverage.
    d. To an individual who has obtained coverage as an eligible individual under subdivision d of subsection 5.
    e. To an individual who has obtained coverage as an eligible individual under subparagraph d of paragraph 1 of subdivision a of subsection 5.
15. An individual is not eligible for coverage through the association if:
    a. The individual is enrolled in health benefits with the state's medical assistance program.
    b. The individual has previously terminated association coverage unless twelve months have lapsed since such termination. This limitation does not apply to an applicant who is a federally defined eligible individual as defined under subparagraph d of paragraph 1 of subdivision a of subsection 5 or subdivision b of subsection 5.
    c. The association has paid out one million dollars in benefits on behalf of the individual.
    d. The individual is imprisoned under federal, state, or local authority. This limitation does not apply to an applicant who is a federally defined eligible individual as defined under subdivision b of subsection 5.
    e. The individual's premiums are paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization, or the individual's employer. However, this subdivision does not apply if the individual's premiums are paid for or reimbursed under a program established under the federal Trade Adjustment Assistance Reform Act of 2002 [Pub. L. 107-210; 116 Stat. 933].
16. A period of creditable coverage is not counted with respect to the enrollment of an individual who seeks coverage under this chapter if after such period and before the enrollment date, the individual experiences a significant break in coverage which is more than sixty-three days.

**26.1-08-13. Termination of coverage.**

The coverage of an individual who ceases to meet the eligibility requirements of this chapter may be terminated at the end of the policy period for which the necessary premiums have been paid. Coverage under this chapter terminates:

1. Upon request of the covered individual.
2. For failure to pay the required premium subject to a thirty-one-day grace period.
3. When the one million dollar lifetime maximum benefit amount has been reached.
4. If the covered individual is enrolled in health benefits under the state's medical assistance program.
5. If the covered individual is no longer a legal resident of this state, except for an individual who is absent from the state for a verifiable medical or other reason as determined by the board.
6. At the option of the plan, thirty days after the plan makes an inquiry concerning the individual's eligibility or place of residence to which the individual does not reply.

**26.1-08-14. Exempt from premium tax.**

The association is exempt from the insurance premium tax imposed under section 26.1-03-17.