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# Same & Opposite Gender Domestic Partner Rider FAQ

The Blue Cross® Blue Shield® of Michigan and Blue Care Network domestic partner rider is currently available to groups with 1-50 enrolled contracts. A rider is not necessary to extend coverage to same-sex legally married spouses.

Unique underwriting guidelines apply to domestic partners. The complete guidelines can be found in the Blue Cross underwriting manual available on the Blue Cross agent secured portal. Below is an overview and some frequently asked questions:

### What is a domestic partner?

Under this rider, domestic partners are persons who permanently reside together as same or opposite gender domestic partners. An eligible domestic partner is defined as two persons who:

- Are 18 years of age or older
- Are not legally married
- Are not related by blood in a manner that would bar legal marriage
- Have lived together for the past 12 consecutive months
- Have a signed and notarized same gender or opposite gender affidavit on file with the employer

### When are the domestic partner and their dependents eligible for coverage?

Coverage for the domestic partner and any eligible dependent children of the domestic partner takes effect 90-days after the date the application is approved by the group.

### Who is considered an eligible dependent of the domestic partner?

An eligible dependent of the domestic partner is defined as a dependent that is related to the domestic partner by birth, legal adoption, or legal guardianship. Dependents are eligible on the same effective date as the domestic partner and covered through age 26. Exceptions may be available for disabled dependents of domestic partners beyond age 26.

### What are the agent responsibilities?

Agents should obtain and complete any necessary group wide change paperwork to add the domestic partner rider to the group's policy. Standard underwriting rules apply for performing group wide changes. Agents should also consult with their client about the group responsibilities under this rider.

### How does the group elect the domestic partner rider?

The domestic partner rider is not on the Part C agreements and must be hand written on the agreements using the below codes:

Small group, fully insured:
- Blue Cross, fully insured groups: DP-SOG-SG
- Blue Care Network: DPRCOS

Large group community rated, fully insured:
- Blue Cross: DP-SOG-LG
- Blue Care Network: DPRCOS 25-49 ASC group: DP-SOG-ASC

### Is there a cost to add the domestic partner rider?

No, this is a non-rated rider.

### What are the group responsibilities?

When groups add this rider, they agree to:

- Verify eligibility of the domestic partner and dependents coverage
- Obtain proof that the domestic partners have resided together for 12 months. Proof may be established by:
  - Driver's license
  - Voter registration
  - Student ID
  - Rental or mortgage agreement
  - Other specific documentation as requested by underwriting
- Collect, attest, and retain the application which consists of the following:
  - Copies of the ECOS form
  - Notarized affidavit: **Opposite Gender Affidavit** or **Same Gender Affidavit**
  - Record of when the application was approved
- Enforce the 90-day waiting period for coverage to take effect after application approval
  - The group will indicate the effective date for the domestic partner and their eligible
  - dependents. Underwriting approval will not be required.
  - Only the ECOS form indicating the addition of the domestic partner and their effective date shouldbe submitted to the carrier, agent, and/or Managing Agent. This will likely be a separate submissionfrom the employee's actual ECOS form.

### Can the 90-day waiting period be waived?

For the New-to-Blue groups, the 90-day waiting period may be waived at the initial enrollment of the group if all of the following conditions are met:

- Proof that the domestic partner had coverage under the group's prior health insurance carrier for at least90-days prior to the effective date of the BCBSM/BCN coverage
  - The group authorizes waiver of the 90-day waiting period.
  - The domestic partner meets all other eligibility requirements, including the completion of the signedand notarized affidavits.

The waiver applies to only domestic partnerships that exist when the BCBSM/BCN coverage becomes effective. Domestic partnerships that occur after the initial effective date of the BCBSM/BCN coverage will be subject to the 90-day waiting period.

In instances where the domestic partner (or the domestic partner and his or her children) lose eligibility for coverage under another health care plan, BCBSM/BCN will comply with HIPAA and waive the 90-day waiting period if the following conditions are met:

- A letter or other documentation from the domestic partner's former employer or insurance carrier is provided to verify that the domestic partner is no longer eligible for coverage.
    - Standard HIPAA requirements and exclusions will still apply.
    - The letter must be received within 31 days of the loss of eligibility date.

### Additional Considerations

- Only one domestic partner may be covered under a subscriber's contract at one time
- When termination of a partnership occurs, the subscriber must wait one year from the time the previous partner was removed from the contract until adding another domestic partner to the contract.
- Coverage for the domestic partner and any dependent children of the domestic partner will terminate when the partnership ends.
- Dependent children of the domestic partner will not be covered until the domestic partner is covered under the subscriber's contract.
- Domestic partners are not eligible for surviving spouse coverage even if the group has established a retiree division.
- Domestic partners and their dependent children are not eligible for COBRA coverage. When the domesticpartners and/or dependent children become ineligible for group coverage, coverage may be availablethrough a BCBSM or BCN individual plan.
- When group coverage ends, coverage may be available to the subscriber and the domestic partner through a BCBSM or BCN individual plan under separate contracts.



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