2023
Blue Cross and BCN Individual Business Off-Marketplace Eligibility Guide

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- The Table of Contents is the main landing page to navigate through the document
- Access sections by hovering over the page number and Ctrl/click
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The content should not be construed as legal advice or legal opinion under any circumstances

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POLICY STATEMENT

The Individual Business Off-Marketplace Policy outlines the regulatory requirements for subscribers and eligible dependents to enroll in a Blue Cross or Blue Care Network Individual qualified health plan, including Blue Cross dental or vision coverage outside of the exchange. Eligibility requirements for subscribers and dependents are defined in this manual.

While Blue Cross and BCN, in general, follow Marketplace rules for Qualified Health Plans, the Individual Business Off-Marketplace Policy is written only for products sold Off-Marketplace . The rules in this manual are for Off-Marketplace products as determined by applicable state law, and federal regulations. Notwithstanding the foregoing, differences from the On-Marketplace rules may be occasionally noted in this manual.

- Blue Cross or BCN will not collect or use Genetic Information, as defined in the Genetic Information Nondiscrimination Act of 2008, for enrollment or renewal purposes. MCL 500.3407(b).

- As an issuer on the Marketplace, Blue Cross and BCN will adhere to all Marketplace issuer requirements set by the Department of Health and Human Services (HHS) in 45 CFR §155.120 and will not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Blue Cross and BCN will adhere to new or amended federal and state laws as of their effective dates, although revisions to this policy manual to incorporate changes required by those laws may occur subsequent to their effective dates.

PURPOSE

Provides documented eligibility criteria one must fulfill to enroll in Blue Cross or BCN Off-Marketplace individual health plans to maintain consistency in Off-Marketplace enrollment

SCOPE

Off-Marketplace commercial business for Blue Cross and BCN.
This policy does not cover eligibility or enrollment requirements for any Medicare Supplement or Medicare Advantage plans.

RELEASE SUMMARY

2023 Open Enrollment

2023 Open Enrollment Updates:

Section 3: Annual Open Enrollment Period	Open Enrollment again has been extended to January 15, 2023, per HHS Finalized Rule • Enrollment November 1, 2022, to December 15, 2022, will have an effective date of January 1, 2023 • Enrollment December 16, 2022, to January 15, 2023, will have an effective date of February 1, 2023
7.1 General Information: Stand Alone Dental, including Dental with Vision	Removed active medical coverage to enroll in a Stand Alone Dental (SADP) plan including Dental with Vision requirement for Off-Marketplace plans only.
8.2 Stand-Alone Vision Re-Enrollment Restrictions	Section was removed. Stand-alone vision plans are no longer subject to the re-enrollment restrictions.

Section 1: GENERAL ELIGIBILITY

1.1 General Information

Description	• An applicant may choose to apply through the Marketplace or directly to Blue Cross or BCN in an Individual Health Plan Off Marketplace • An applicant may apply for coverage during the Annual Open Enrollment Period or within a time frame allotted by the Special Enrollment Period due to a Qualifying Life Event • A member is not required to have only one type of policy and is not required to have only one policy product. However, there could be implications related to subsidies for people who are otherwise eligible for minimum essential coverage • Sole proprietors may enroll in individual coverage • The applicant may be the individual requesting enrollment, an authorized representative of the individual, or if the individual is a minor or incapacitated, someone legally responsible for the individual

1.2 Catastrophic Plan

CFR	45 CFR 155.305(h)
Description	Value plan for individuals under age 30, or with certain exemptions

The applicant and dependents must meet the general eligibility and dependent eligibility criteria

- Be under age 30 on the effective date
- If over the age of 30 on the effective date
  - A certificate of exception from the Marketplace that confirms hardship or lack of affordable coverage is required to enroll in the Catastrophic plan
  - A paper application along with the certificate of exemption is required for enrollment
- The subscriber and dependents may remain on the Catastrophic plan through the end of the year in which they turned 30
- A Catastrophic plan may be purchased as a child only contract

1.3 Child Only Enrollment

Description	A contract without a parent or legal guardian as a covered member

- A child only applicant must meet general eligibility requirements
- Be under age 21 on the effective date for health plans
- Be under age 19 on the effective date for dental plans
- When a contract is issued to a child, only 1 child may be on each contract
- Multiple children within a family, each child must have an application completed and submitted on their behalf
- Child only applications for medical or dental coverage must be submitted by a parent or legal guardian for children under age 18
- If a child is an emancipated minor and can enter into a binding contract, according to state guidance MCL 500.2205, they may submit their own application
  - A court order granting emancipation may be required
- Child only applicants age 18 to age 20 on the effective date must submit their own application. See General Information

Section 1: GENERAL ELIGIBILITY (continued)

1.4 Citizenship – Social Security Number Requirement

Description	Applicants, dependent and existing members must be a U.S. citizen or lawfully present in the United States

- An applicant must provide a valid social security number (SSN) upon enrollment for everyone on the contract age 12 months or older
- If an applicant or dependent doesn't have an SSN but is a permanent United States resident, a federally issued Individual Tax Identification Number (ITIN) will be required
- The SSN or ITIN should always be provided at the time of enrollment if one is available, regardless of age
- Gaining status as a United States citizen, national or becoming a lawfully present individual is not a qualifying event for Off-Marketplace enrollment
- Proof of citizenship may be requested at any time. Supportive documentation may include:
  - Certified U.S. birth certificate,
  - Valid, unexpired, United States passport,
  - Permanent Resident Card (Green Card) I-551,
  - Certificate of Citizenship (N-560 or N-561)

Acceptable situations where an SSN or ITIN may not be available:

- A child only applicant or dependent over the age of 12 months in an adoptive situation
- An applicant or dependent over 12 months who does not have an SSN or ITIN but lawfully present in the United States. Blue Cross and BCN will accept a paper application and lawfully present documentation

1.5 Medicare Eligibility

Description	An applicant or dependent applying for an individual health plan cannot be entitled to benefits under Medicare part A or enrolled under Medicare part B

- Any exception to the Medicare eligibility guidelines would require supporting information from the Centers for Medicare and Medicaid Services (CMS) and may be based on the following:
  - Not yet signed up and know there are penalties for late Medicare enrollment
  - Over age 65, eligible for premium-free Part A, not collecting social security and not enrolled in part A or part B
  - Not eligible for premium-free part A and drops, or never enrolls in part A or part B
  - Eligible for premium-free Part A, but not enrolled
  - Eligible for premium-free Part A based on end-stage renal disease (ESRD), but not enrolled
  - Drops premium-free Part A and pays back all retirement benefits and Medicare costs incurred
  - When applying for a stand-alone dental, vision or dental with vision plan

1.6 Medicare Anti-Duplication Provision

Description	Prohibits issuers from issuing or renewing individual market coverage if they have knowledge an enrollee in individual market coverage is entitled to Medicare Part A or enrolled in Medicare Part B if it would duplicate benefits to which the enrollee is entitled, unless renewal is effectuated under the same policy and contract of insurance

Section 1: GENERAL ELIGIBILITY (continued)

1.7 Network

Description	A group of facilities, providers and suppliers a health carrier contracts with to provide health care.

- Applicants, dependents and existing members choosing a product with a network platform from Blue Cross or BCN, must reside within the service area for that product
- The applicant must use hospitals, providers and other licensed facilities or health care providers that participate with the Blue Cross or BCN alternative network platform for services to be covered

1.8 Payment

Description	Premium payment will only be accepted from the subscriber, spouse or, when applicable, the parent, blood relative, legal guardian or other authorized person or entity.

- Authorized entities to pay premium under the law (45 CFR 156.1250)
  - Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act
  - Indian tribes/tribal organizations
  - Federal and State Government programs
  - Local Government programs, including counties and municipalities
- Other authorized entities:
  - The Pink Fund
- Non-authorized entities for payment include:
  - Physicians and hospitals
  - Medical centers such as dialysis and surgical centers
  - Employers, except when offering an HRA or a qualified small employer health reimbursement arrangement for individual coverage

1.9 Residency

CFR	45 CFR 155.305(a)(3)
Description	• Applicant, dependent or existing member currently living in Michigan, and • Intends to reside in Michigan, including without a fixed address, or • Has committed to employment in Michigan or is seeking employment (whether or not currently employed)

- Intent of Michigan residency, including dependent residence, must be provided upon request
  - Supportive documentation may include school registration, valid Michigan driver license, state ID, vehicle registration, lease, pay stub, utility bill or any type of bill or document that shows intent to live in Michigan
- Applicant, dependent or existing member is not eligible to begin coverage prior to having a Michigan address
- A member or dependent may temporarily live elsewhere and still qualify as a Michigan resident
  - e.g. a college student
- Applicants, dependents and existing members choosing a product with a network platform from Blue Cross or BCN, must reside within the service area for that product
- Individuals visiting Michigan for transitory purposes, for example but not limited to, obtaining medical care, personal pleasure or to attend a business matter do not meet the residency requirement

Section 2: DEPENDENT ELIGIBILITY

2.1 Dependent Eligibility

Description	• A dependent is defined as a person who is or may become eligible for health care coverage as a member on a subscriber's contract under the terms of a health plan because of a relationship to the subscriber • Dependent, spouse and children must also meet general eligibility criteria • A dependent child's spouse or children are not eligible for coverage under the subscriber's contract

2.2 Adoption or Placement of Adoption

Description	Adoptive children are an eligible dependent under an individual contract

- A child is eligible for coverage as of the date of final adoption or the placement of the child
- A social security number is required. However, it is acceptable in some adoptive situations when a social security number may not be available for a child over 12 months
  - A paper application will be required
  - The social security number should be provided as soon as it's available
- A court order verifying placement or final adoption is required

2.3 Attained Age 26

Description	Twenty-six-year old dependent children who are not certified as disabled are no longer eligible for coverage on their parent's contract

- Dependent children will automatically be removed from their parents Blue Cross or BCN contract at the end of the year in which they turned age 26
- Notification will be made regarding the termination of the dependent child's coverage
- This is a Special Enrollment Event for the dependent and all other members on the contract

2.4 Court Order or Child Support Order

Description	A court order or child support order to provide health care coverage to the children named on the order

- May enroll as a dependent on a family contract or in a child only policy
- Copy of the court order or child support order is required
- According to state guidance, MCL 500.3406h: Notification of the court order or child support order to provide health coverage over 60 days may be considered if there was failure of notification by a parent. The application can be made by a Friend of the Court or by other parent through a Friend of the Court

Section 2: DEPENDENT ELIGIBILITY (continued)

2.5 Dependent Children

Description	A child is an eligible dependent when related to the subscriber by birth, marriage, legal adoption, legal guardianship or foster child

- Must be under age 26 on the effective date of coverage
- Eligible to remain on the contract until the end of the year in which they turn age 26, unless certified as a disabled dependent
- A social security number is required at the time of enrollment for all dependents age 12 months and older. See Adoption or Placement of Adoption
- If a dependent does not have a social security number but is a permanent United States resident, a federally issued Individual Tax Identification Number is required
- The dependent must be a permanent Michigan resident
- They may live somewhere else temporarily, as in the case of college students and still qualify as a Michigan resident. See Residency
- If a dependent has a different last name than the subscriber documentation may be requested at any time to validate dependents status
- A dependent child's spouse or children are not eligible as dependents

2.6 Disable Dependent

Description	An unmarried dependent who is incapable of self-support due to developmental disability or physical disability

- The dependent must not be eligible for Medicare part A or enrolled in Medicare part B
- A physician certification regarding the child's disability must be received within 31 days after the end of the year in which the child turned 26. The information will be evaluated to determine if the dependent meets this definition
- If an existing disabled dependent becomes eligible or enrolled in Medicare and the subscriber changes plans, they are no longer eligible to remain as a dependent in the new plan. See Medicare Anti-Duplication Provision
- A disabled child age 26 years old or older may remain enrolled as a dependent with their parent or legal guardian if they were included on their prior Blue Cross or BCN contract. The prior coverage must have been active within 60 days of enrollment in the Individual contract. A paper application is required
- In the case where a disabled dependent, over age 26 is coming from a non-Blue Cross or BCN plan, they must apply separately with their own application.

2.7 Legal Guardianship

Description	A child qualifies as an eligible dependent when legal guardianship is granted to the subscriber by a judge via court order

- The child may enroll on a child only policy or as a dependent on the guardian's contract
- The child may be added to an existing Blue Cross or BCN contract
- Allows for a new plan selection during a Special Enrollment Period when legal guardianship is newly granted
- A copy of the court order appointing guardianship is required

Section 2: DEPENDENT ELIGIBILITY (continued)

2.8 Petition for Legal Guardianship

Description	A child qualifies as an eligible dependent when the subscriber petitions a court for legal guardianship and the child has established residency with the subscriber

- Applies to Blue Cross or BCN Off-Marketplace members only
- The child may be added as a dependent to existing coverage during the Special Enrollment Period for becoming a dependent.
- Petition for Legal Guardianship does not allow for a new plan selection during a Special Enrollment Period
- A copy of the Petition for Legal Guardianship with a sworn statement the child has established residency with the subscriber is required

2.9 Spouse

Description	A subscriber spouse is defined as the legal husband or wife of the subscriber as recognized in the jurisdiction under the law where the marriage occurred

- Social security number is required at time of enrollment
- If the spouse has no social security number but is a permanent United States resident, a federally Issued Individual Tax Identification Number is required
- Domestic partners, same or opposite sex, are not eligible to enroll as a dependent
- A marriage certificate may be requested at any time to validate the marriage

Section 3: ANNUAL OPEN ENROLLMENT PERIOD

Applications	**November 1, 2022 through January 15, 2023**
Effective Date	• Enrollment November 1, 2022 to December 15, 2022 will have an effective date of January 1, 2023 • Enrollment December 16, 2022 to January 15, 2023 will have an effective date of February 1, 2023

- Must meet the general and dependent eligibility requirements
- A Qualifying Life Event is not required to obtain coverage
- A subscriber may update information on their current policy, add or delete dependents and make other plan changes using a change of status form
- An application may be required. See Coverage Change
- The effective date of the new plan will be determined on the Annual Open Enrollment application submission date
- Once the Annual Open Enrollment Period is closed, new plan requests will no longer be accepted unless due to a qualifying event

Section 4: SPECIAL ENROLLMENT PERIOD (SEP)

CFR	45 CFR 155.420
Description	• SEP is the time during which an individual or applicant who experiences a certain Qualifying Life Event may enroll or change coverage outside of the Annual Open Enrollment Period • Length of enrollment period and effective date assignment is triggered by a Qualifying Life Event and applies to new enrollment and existing member changes • The SEP ends when the allowable timeframe concludes • Existing members can change their plan or make eligible changes more than once within the SEP • Supporting documentation to confirm the Qualifying Life Event and validate the SEP is required within 30 days of enrollment

- During a Special Enrollment Period an individual may:
  - Apply for coverage
  - Add or remove dependents
  - Enroll in a new health plan
  - Enroll in a plan as a card holder
- Existing members can submit a change of status form unless the change involves:
  - Plan changes between issuers, (Blue Cross to BCN or vice versa)
  - Adding a stand-alone dental or vision plan
  - A change in card holder

Section 5: QUALIFYING LIFE EVENTS

5.1 General Information

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)
Description	• A Qualifying Life Event is required to enroll in health coverage or make changes to existing coverage outside of the Annual Open Enrollment Period • General and dependent eligibility guidelines apply to all individuals and Qualifying Life Events A change in tobacco use is not a qualifying event • A member may change smoker status with a plan change during the Annual Open Enrollment Period or during a Special Enrollment Period due to a Qualifying Life Event. • An attestation they have not used tobacco for at least 6 months is required

- A Qualifying Life Event provides enrollment rights to the individual who experiences the event, and others on the contract in some cases
- Enrollment rights, including effective date assignment, are unique to the Qualifying Life Event
- The date of the Qualifying Life Event is what triggers the Special Enrollment Period which is a specified amount of time for an individual to obtain coverage or make changes to existing off-marketplace coverage
    - If a qualified individual, enrollee, or dependent did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a triggering event occurred, the qualified individual, enrollee, or when applicable, his or her dependent can select a new plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event.
- Documentation to support a Qualifying Life Event is required within 30 days of enrollment
- If a member becomes eligible for other coverage, including group, Medicaid or CHIP, they do not have to cancel their individual coverage
- Prior coverage must meet the definition of minimum essential coverage, and allows prior coverage for pregnancy Medicaid, CHIP unborn child and Medically Needy Medicaid
- A short-term policy does not satisfy prior coverage requirements

Section 5: QUALIFYING LIFE EVENTS (continued)

5.2 Birth

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(2)(i) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(b)(3)(i)
Special Enrollment Period	• May apply within 60 days after the date of event
Effective Date Options	• Date of event, or • 1st of the month following the date of application

- Must meet general and dependent eligibility guidelines
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- Allows for other eligible dependents to be included with the enrollment of the child experiencing the event
- No prior coverage requirements
- Documentation supporting the event is required within 30 days of enrollment
- The parent has an enrollment right and so does the child that becomes a dependent, neither is required by federal law to enroll on the same contract

5.3 Adoption, Placement for Adoption

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(2)(i) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(b)(3)(i)
Special Enrollment Period	• May apply within 60 days after the date of event
Effective Date Options	• Date of event, or • 1st of the month following the date of application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows plan changes when added to an existing off-marketplace contract
- Other eligible dependents may be included with the individual experiencing the event
- No prior coverage requirements
- Documentation supporting the event is required within 30 days of enrollment
- The qualifying individual that gains a dependent has an enrollment right and so does the child or individual that becomes a dependent, neither is required by federal law to enroll on the same contract

Section 5: QUALIFYING LIFE EVENTS (continued)

5.4 Court Order, Child Support Order, Legal Guardianship

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(2)(i) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(b)(3)(i)
Special Enrollment Period	• May apply within 60 days after the date of event
Effective Date Options	• Date of event, or • 1st of the month following the date of application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows plan changes when added to an existing off-marketplace contract
- Other eligible dependents may be included with the individual experiencing the event
- No prior coverage requirements
- Documentation supporting the event is required within 30 days of enrollment
- The qualifying individual that gains a dependent has an enrollment right and so does the child or individual that becomes a dependent, neither is required by federal law to enroll on the same contract

5.5 Petition for Legal Guardianship

	Off-Marketplace only
Special Enrollment Period	• May be added within 60 days after the date of event
Effective Date Options	• Date of event, or • 1st of the month following the date of application

- Must meet the general and dependent eligibility requirements
- May only be added to an existing off-marketplace contract
- A change of status form is required
- Does not allow plan changes
- Other eligible dependents may be added with the individual experiencing the event
- No prior coverage requirements
- Documentation supporting the event, including a sworn statement verifying the dependent established residency with the subscriber, is required within 30 days of enrollment

Section 5: QUALIFYING LIFE EVENTS (continued)

5.6 Foster Care Placement

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(2)(i) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(b)(3)(i)
Special Enrollment Period	• May apply within 60 days after the date of event
Effective Date Options	• Date of event, or • 1st of the month following the date of application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- Other eligible dependents may be included with the individual experiencing the event
- No prior coverage requirements
- Documentation supporting the event is required within 30 days of enrollment
- The qualifying individual that gains a dependent has an enrollment right and so does the child or individual that becomes a dependent, neither is required by federal law to enroll on the same contract

5.7 Marriage

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(2)(i) 45 CFR 155.420(b)(1)(2)(3)
Special Enrollment Period	• May apply within 60 days after the date of event
Effective Date Option	• 1st of the month following the date of application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- Other eligible dependents may be included with the spouse experiencing the event
- Prior coverage requirement: At least one spouse enrolling on the contract must demonstrate minimum essential coverage for 1 or more days within the 60 days preceding the event unless one of the following is met during their most recent preceding enrollment period
  - They lived in a foreign country or United States Territory
  - They lived in an area where no QHP was offered through the Exchange
    - Note: Blue Cross and BCN QHP plans are offered throughout the state
  - They are an Indian as defined by section 4 of the Indian Health Care Improvement Act
- Off-Marketplace will allow an enrolling spouse to fulfill the prior coverage requirement when the other non-enrolling spouse meets the prior coverage requirement but is currently ineligible to enroll on the contract because he/she is eligible or enrolled in Medicare.
  - A copy of the Medicare card is required in addition to the documentation for marriage
- Documentation supporting the event is required within 30 days of enrollment
- Dental or vision only coverage is not minimum essential health coverage and therefore does not qualify to purchase medical coverage

Section 5: QUALIFYING LIFE EVENTS (continued)

5.8 Cessation of Dependent Status

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(2)(i) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(b)(3)(i)
Special Enrollment Period	• May apply 60 days prior or within 60 days after loss of coverage
Effective date for 60 days **prior** to loss of coverage	• Day after loss of coverage date, or 1st of the month following loss of coverage
Effective date options for within 60 days **after** loss of coverage	• Day after loss of coverage date, or • 1st of the month following application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- Prior minimum essential group or individual coverage is required
- Dental or vision only coverage does not qualify to purchase medical coverage
- Documentation supporting the event is required within 30 days of enrollment
- Aging off a pediatric dental plan, see Pediatric Dental Guidelines

5.9 Death of Policy Holder

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(d)(2)(ii) 26 CFR 54.9801-6(a)(3)(i)(ii)(iii) 45 CFR 155.420(b)(3)(i)
Special Enrollment Period	• May apply within 60 days after the date of death
Effective Date Options	• Day after loss of coverage date, • 1st of the month following the date of application

- Must meet the general and dependent eligibility requirements
- May enroll in coverage or be added to an existing off-marketplace contract
- Allows for a plan change when added to an existing off-marketplace contract
- Other eligible dependent may be included in the enrollment regardless of prior coverage
- Prior minimum essential group or individual coverage is required
- Dental or vision only coverage does not qualify to purchase medical coverage
- Documentation supporting the event and prior coverage is required within 30 days of enrollment
- ID cards from other carriers are not an acceptable for proof of prior coverage

Section 5: QUALIFYING LIFE EVENTS (continued)

5.10 Discontinued or Decertified Individual Health Plan

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(1)(i) 45 CFR 155.420(b)(3)(i)
Description	Loss of minimum essential coverage from another carrier that has discontinued a plan, discontinued all plans or has been decertified for qualified health plans
Special Enrollment Period	• May apply 60 days prior or within 60 days after the loss of coverage
Effective date for 60 days **prior** to the loss of coverage	• 1st of the month following loss of coverage, or • If the event is on the 1st of the month, then date of the event
Effective date options for within 60 days **after** the loss of coverage	• 1st of the month following application

- Must meet the general and dependent eligibility requirements
- The individual who lost prior coverage must be included in the enrollment
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- May enroll for coverage or be added to an existing plan
- Documentation of prior coverage is required within 30 days of enrollment
- ID cards from other carriers are not acceptable piece of supporting documentation

5.11 Divorce or Legal Separation

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(d)(1)(i)	26 CFR 54.9801-6(a)(3)(i)(ii)(iii) 45 CFR 155.420(b)(3)(i)
Continuous Coverage	Blue Cross and BCN offers continuous coverage to individuals who lose a qualified health plan, including other carriers and apply within the SEP timeframe to avoid a gap in coverage. **If the applicant elects continuous coverage an effective date will be** • Day after the prior health plan termination date • Continuous coverage could result in retroactive premium	
Special Enrollment Period	• May apply within 60 days after the event date	
Effective Date Options	• Day after loss of coverage date, • 1st of the month following the date of application	

- Must meet the general and dependent eligibility requirements
- May enroll in coverage or be added to an existing off-marketplace contract
- Allows for a plan change when added to an existing off-marketplace contract
- Other eligible dependent may be included in the enrollment regardless of prior coverage
- Prior minimum essential group or individual coverage is required
- Dental or vision only coverage does not qualify to purchase medical coverage
- Documentation supporting the event and prior coverage is required within 30 days of enrollment
- ID cards from other carriers are not an acceptable for proof of prior coverage

Section 5: QUALIFYING LIFE EVENTS (continued)

5.12 Domestic Abuse or Spousal Abandonment

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(10)	45 CFR 155.420(b)(3)(i)
Description	• Individual subject to domestic abuse or spousal abandonment, or a dependent or unmarried victim within the household, seeking to apply for coverage separate from the perpetrator of the abuse or abandonment	
Special Enrollment Period	• May apply within 60 days from the date of event	
Effective Date Option	• Event Date, or • 1st of the month following the date of application	

- Must meet general and dependent eligibility requirements
- Allows for other eligible dependent children in the enrollment
- No prior coverage is required
- No documentation is required – documentation may be accepted if provided by the enrollee within 30 days of enrollment

5.13 Involuntary Loss of an Individual Health Plan

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(1)(i)	26 CFR 54.9801-6(a)(3)(i) 45 CFR 155.420(b)(3)(i)
Description	Involuntary loss of coverage that is not a result of: • Termination due to an individual's failure to pay premium • An act of fraud by the individual • Situations allowing for a rescission • Voluntary termination of coverage • Short term policy	
Continuous Coverage	Blue Cross and BCN offers continuous coverage to individuals who lose a qualified health plan, including other carriers and apply within the SEP timeframe to avoid a gap in coverage. **If the applicant elects continuous coverage an effective date will be** • Day after the prior health plan termination date • Continuous coverage could result in retroactive premium	
Special Enrollment Period	• May apply 60 days prior or within 60 days after the loss of coverage	
Effective date for 60 days **prior** to loss of coverage	• Event Date, or • 1st of the month following loss of coverage	
Effective date options for within 60 days **after** loss of coverage	• Event Date, or • 1st of the month following application	

- Must meet the general and dependent eligibility requirements
- The individual who lost prior coverage must be included in the enrollment
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- May enroll for coverage or be added to an existing plan
- Loss of dental or vision only coverage does not qualify to purchase medical coverage
- Documentation supporting the event and prior coverage is required within 30 days of enrollment
- ID cards from other carriers are not an acceptable piece of supporting documentation

Section 5: QUALIFYING LIFE EVENTS (continued)

5.14 Loss of Minimum Essential Coverage from Group Plan or COBRA

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(d)(1)(i)	26 CFR 54.9801-6(a)(3)(i)(ii)(iii) 45 CFR 155.420(b)(3)(i)
Description	Loss of minimum essential coverage from group coverage as a result of: • Termination of the covered employee's employment: – Resigned, reduction in force or termination of employment • Employer no longer offers coverage • Plan no longer offers benefits to the class of similarly situated individuals • Reduction in hours of the covered employee's employment below the minimum necessary to maintain coverage • Employee no longer resides, lives, or works in the service area of the plan and no other benefit package is available to the employee • Termination of current employer contribution • Exhaustion of COBRA **Loss of minimum essential coverage from group coverage does not include:** • Termination due to an individual's failure to pay any required contribution, including COBRA premium • An act of fraud by the individual • Situations allowing for a rescission • Loss of individual coverage purchased using a Qualified Health Reimbursement Arrangement provided by a qualified small employer • Voluntary termination of employer health coverage	
Continuous Coverage	Blue Cross and BCN offers continuous coverage to applicants who lose a qualified employer sponsored health plan, including other carriers, when they experience a Qualifying Life Event for loss of minimum essential coverage and apply within the SEP timeframe to avoid a gap in coverage. **If the applicant elects continuous coverage an effective date will be**: • Day after the prior group termination date • Continuous coverage could result in retroactive premium	
Special Enrollment Period	• May apply 60 days prior or within 60 days after the loss of coverage	
Effective date for 60 days **prior** to loss of coverage	• Day after loss of coverage or • 1st of the month following loss of coverage	
Effective date for within 60 days **after** loss of coverage	• Day after loss of coverage, • 1st of the month following application	

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- The individual who lost prior coverage must be included in the enrollment or with the addition
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- Prior group medical coverage is required
- Loss of dental or vision only coverage does not qualify to purchase medical coverage
- Documentation supporting the event and prior group coverage from Blue Cross, BCN or other carrier group health plan is required within 30 days of enrollment
- Off-Marketplace allows dependents with proof of prior coverage from other carrier group or COBRA to enroll in a Blue Cross or BCN Off-Marketplace plan. An application and proof of prior coverage is required
- ID cards from other carriers are not an acceptable piece of supporting documentation

Section 5: QUALIFYING LIFE EVENTS (continued)

5.15 Loss of Medicaid or CHIP

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(1)(i) 45 CFR 155.420(b)(3)(i)
Description	• Individual was enrolled and lost coverage in Medicaid or CHIP • The date of the loss of coverage is the last day the individual would have coverage under his or her previous coverage • See Medicaid or CHIP ineligible determination for requirements of a denied application 45 CFR 155.420(d)(11)
Special Enrollment Period	• May apply 60 days after or within 60 days prior to the loss of coverage
Effective date for 60 days **prior** to the loss of coverage	• Day after loss of coverage, or • 1st of the month following loss of coverage
Effective date options for within 60 days **after** the loss of coverage	• Day after loss of coverage, • 1st of the month following application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- Loss of coverage cannot be voluntary, due to failure to pay premium or rescission situations
- The individual who lost the coverage must be included in the enrollment or with the addition
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- Documentation supporting the event is required within 30 days of enrollment
  - Medicaid or CHIP termination letter
  - Non-renewal of CHIP coverage is not considered voluntary loss
- If an existing member becomes eligible and enrolls for Medicaid/CHIP, they do not have to cancel their Individual coverage

Section 5: QUALIFYING LIFE EVENTS (continued)

5.16 Loss of Medically Needy Medicaid Coverage

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(b)(3)(i) 45 CFR 1556.420(d)(1)(iv)
Description	• Allows for enrollment once per calendar year for the loss of medically needy coverage • The date of the loss of coverage is the last day the consumer would have medically needy coverage
Special Enrollment Period	• May apply 60 days prior or within 60 days after the loss of coverage
Effective date for 60 days **prior** to the loss of coverage	• 1st of the month following loss of coverage
Effective date for within 60 days **after** the loss of coverage	• 1st of the month following application

- Must meet general and dependent eligibility guidelines
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes, when added to an existing off-marketplace contract
- The individual who lost the coverage must be included in the enrollment or with the addition
- Loss of coverage cannot be voluntary or due to failure to pay premium or situations allowing for a rescission
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- Documentation to support the event is required within 30 days of enrollment
  - Letter from HHS indicating the date and reason for loss

5.17 Loss of Non-Calendar Year Health Insurance Policies

CFR	45 CFR 155.420(b)(3)(i) 45 CFR 147.104(b)(2) 45 CFR 155.420(d)(1)(ii)
Description	• The qualified individual and dependents currently enrolled in a non-calendar year group or individual plan become eligible for an SEP during the plan's renewal period or when they become newly eligible for a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) • The subscriber and dependent each have an enrollment right, therefore are not required to enroll or renew together • The date of the loss of coverage is the last day of the plan or policy year
Special Enrollment Period	• May apply 60 days prior or within 60 days after the loss of coverage
Effective date for 60 days **prior** to the loss of coverage	• 1st of the month following loss of coverage
Effective date for within 60 days **after** the loss of coverage	• 1st of the month following application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- The individual who lost the coverage must be included in the enrollment or with the addition
- Loss of coverage cannot be due to failure to pay premium or rescission situations
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- Documentation to support the event is required within 30 days of enrollment
  - Carrier renewal letter

Section 5: QUALIFYING LIFE EVENTS (continued)

5.18 Loss of Pregnancy Related Medical Coverage

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(1)(iii) 45 CFR 155.420(b)(3)(i)
Description	• Loses pregnancy-related coverage or loses access to health care services through coverage provided to a pregnant woman's unborn child • The date of the loss of coverage is the last day the individual would have pregnancy-related coverage or access to health care services through the unborn child coverage
Special Enrollment Period	• May apply 60 days prior or within 60 days after the loss of coverage
Effective date for 60 days **prior** to the loss of coverage	• 1st of the month following loss of coverage
Effective date for within 60 days **after** the loss of coverage	• 1st of the month following application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- The child who lost prior Medicaid or CHIP coverage must be included in the enrollment
- The SEP for Loss of CHIP includes eligibility to women who lost access to health care services they had received through CHIP coverage through their unborn child
- Loss of coverage cannot be voluntary, due to failure to pay premium or rescission situations
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- Documentation to support the event is required within 30 days of enrollment
  - Letter from HHS or state agency indicating the date and reason for loss

5.19 Loss of Student Health Plan

CFR	45 CFR 155.420(b)(1)(2)(3) 45 CFR 147.104(b)(2) 45 CFR 155.420(b)(3)(i)	45 CFR 155.420(d)(1)(i) 26 CFR 54.9801-6(a)(3)(i)(ii)(iii)
Description	• Loss of Student Health Coverage due to graduation, or • No longer enrolled in higher education	
Special Enrollment Period	• May apply within 60 days prior or after the loss of coverage	
Effective date for 60 days **prior** to the loss of coverage	• 1st of the month following loss of coverage, or • If the event is on the 1st of the month, then date of the event	
Effective date for within 60 days **after** the loss of coverage	• 1st of the month following application	

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- The individual who lost prior coverage must be included in the enrollment or with the addition
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- Loss of dental or vision only coverage does not qualify to purchase medical coverage
- Documentation supporting the event and prior coverage is required within 30 days of enrollment

Section 5: QUALIFYING LIFE EVENTS (continued)

5.20 Medicaid or CHIP Ineligible Determination

CFR	45 CFR 155.420(b)(3)(i) 45 CFR 147.104(b)(2) 45 CFR 155.420(d)(11)
Description	• **State action**: Consumers and dependents who applied for coverage on the Exchange during Open Enrollment Period or Special Enrollment Period, are assessed by the exchange as potentially eligible for Medicaid or Children's Health Insurance Program and the state agency decision of ineligibility comes after the end of the OEP or SEP timeframe • **Consumer action**: Consumers and dependents who applied for Medicaid or CHIP coverage at the state agency during the Annual Open Enrollment period and are determined ineligible for Medicaid or CHIP after open enrollment has ended
Special Enrollment Period	• May apply 60 days prior or within 60 days after the event date
Effective date for 60 days **prior** to loss of coverage	• Day after loss of coverage date, or • 1st of the month following loss of coverage
Effective date options for within 60 days **after** loss of coverage	• Day after loss of coverage date, • 1st of the month following application

- Must meet general and dependent eligibility guidelines
- May enroll for coverage or be added to an existing off-marketplace contract
- The individual who applied for Medicaid or CHIP must be included in the enrollment
- Other eligible dependents may be included in the enrollment
- No prior coverage required
- Documentation of the decision and date of decision from the state is required within 30 days of enrollment

5.21 Move Out of Plan Area with Loss of Coverage

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(b)(3)(i) 45 CFR 155.420(d)(7)
Description	• Individual no longer lives in the plan service area due to a permanent move • Includes moves from another state, U. S. territory or outside the country
Special Enrollment Period	• May apply 60 days prior or within 60 days after the loss of coverage
Effective date for 60 days **prior** to loss of coverage	• Day after loss of coverage date, or • 1st of the month following loss of coverage
Effective date for within 60 days **after** loss of coverage	• 1st of the month following application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- The eligible individual must be included in the enrollment or with the addition
- Other eligible dependents may be included in the enrollment regardless of prior coverage
- Documentation supporting the event and prior coverage is required within 30 days of enrollment
- Exceptions for prior coverage during the 60 days preceding the event:
    - They lived in a foreign country or U. S. territory
    - They lived in an area where no Qualified Health Plan was offered on the exchange
        - ❖ Note: Blue Cross and BCN QHP plans are offered throughout the state
    - They are an Indian as defined in section 4 of the Indian Health Care improvement Act
    - Not applicable to off-market

Section 5: QUALIFYING LIFE EVENTS (continued)

5.22 Moving Gaining Access to a New Plan

CFR	45 CFR 155.420(b)(3)(i) 45 CFR 147.104(b)(2) 45 CFR 155.420(d)(7)
Description	• Gains access to new plans because of a permanent move • Not intended for a short term move when the consumer does not plan to stay in the new location, including when the consumer is admitted to a hospital or treatment facility • Includes release from incarceration
Special Enrollment Period	• May apply 60 days prior or within 60 days of move
Effective date for 60 days **prior** to loss of coverage	• Day after loss of coverage date, or • 1st of the month following loss of coverage
Effective date options for within 60 days **after** loss of coverage	• 1st of the month following application

- Must meet general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract with plan change
- The individual gaining access to new plan must be included in the enrollment
- Other eligible dependents may be included with the individual experiencing the event
- Coverage is required for a minimum of 1 or more days within the 60 days preceding the move but does not require loss of coverage
- Documentation supporting the event and prior coverage is required within 30 days of enrollment
- Documentation to support the old and new address
- Exceptions for prior coverage during the 60 days preceding the event:
    - They lived in a foreign country or U. S. territory
    - They lived in an area where no Qualified Health Plan was offered on the exchange
        - ❖ Note: Blue Cross and BCN QHP plans are offered throughout the state
    - They are an Indian as defined in section 4 of the Indian Health Care improvement Act
- Dental or vision only coverage does not qualify to purchase medical coverage

Section 5: QUALIFYING LIFE EVENTS (continued)

5.23 New Access to Individual HRA or QSEHRA

CFR	45 CFR 155.420(1)(ii)(14)
Description	• The qualified individual, enrollee, or dependent newly gains access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) • The date triggering the SEP is the first day on which the ICHRA or QSEHRA takes effect • This event does not include change in funding dollar amounts in existing ICHRA or QSEHRA
Special Enrollment Period	May apply 60 days prior or within 60 days after becoming newly eligible for an ICHRA or QSEHRA
Effective date for 60 days **prior** to the event	• 1st of the month following event, or • If the event is on the 1st of the month, then date of the event
Effective date options for within 60 days **after** the event	• 1st of the month following application

- Must meet the general and dependent eligibility requirements
- May enroll for coverage or be added to an existing off-marketplace contract
- Allows for plan changes when added to an existing off-marketplace contract
- The eligible individual must be included in the enrollment or with the addition
- Other eligible dependents may be included with the individual experiencing the event
- Enrollee is not enrolled in the ICHRA/QSEHRA on the day immediately prior to the event
- No prior coverage required
- Documentation supporting the event is required within 30 days of enrollment
- If an individual is non-renewing a non-calendar year ICHRA/QSEHRA, they may be eligible for the SEP that also applies to individuals in a Non-Calendar Year Health Plans. See Non-Calendar Year Health Plan

5.24 Policy Holder Became Eligible for and Enrolled in Medicare

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(b)(1)(2)(3) 45 CFR 155.420(d)(1)(i) 26 CFR 54.9801-6(a)(3)(i)(ii)(iii)
Continuous Coverage	Blue Cross and BCN offers continuous coverage to individuals who lose a qualified health plan, including other carriers and apply within the SEP timeframe to avoid a gap in coverage. **If the applicant elects continuous coverage an effective date will be** • Day after the prior health plan termination date • Continuous coverage could result in retroactive premium
Special Enrollment Period	• May apply 60 days prior or within 60 days after the event date
Effective date for 60 days **prior** to loss of coverage	• Day after loss of coverage date, or • 1st of the month following loss of coverage
Effective date options for within 60 days **after** loss of coverage	• Day after loss of coverage date, • 1st of the month following application

- Must meet the general and dependent eligibility requirements
- May enroll in coverage or be added to an existing off-marketplace contract
- Allows for a plan change when added to an existing off-marketplace contract
- Other eligible dependent may be included in the enrollment, regardless of prior coverage
- Prior minimum essential group or individual coverage is required
- Dental or vision only coverage does not qualify to purchase medical coverage
- Documentation supporting the event and prior coverage is required within 30 days of enrollment
- ID cards from other carriers are not an acceptable for proof of prior coverage

Section 5: QUALIFYING LIFE EVENTS (continued)

5.25 Cessation of Contribution to COBRA

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(b)(3)(i) 45 CFR 155.420(d)(15) 45 CFR 155.420(b)(2)(iv) 45 CFR 155.420(c)(2)
Description	• Employer contribution or government subsidy to a COBRA premium on a group health plan completely ceases such that the individual becomes responsible for 100% of the COBRA premium **and** • Individual voluntarily ends COBRA continuation coverage. • The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized.
Continuous Coverage	Blue Cross and BCN offers continuous coverage to individuals who lose a qualified health plan, including other carriers and apply within the SEP timeframe to avoid a gap in coverage. **If the applicant elects continuous coverage an effective date will be** • Day after the prior health plan termination date • Continuous coverage could result in retroactive premium
Special Enrollment Period	• May apply 60 days prior or within 60 days after the event date
Effective date for 60 days **prior** to loss of coverage	• Day after loss of coverage date, or • 1st of the month following loss of coverage
Effective date options for within 60 days **after** loss of coverage	• Day after loss of coverage date, • 1st of the month following application

- Must meet the general and dependent eligibility requirements
- May enroll in coverage or be added to an existing off-marketplace contract
- Allows for a plan change when added to an existing off-marketplace contract
- Other eligible dependent may be included in the enrollment, regardless of prior coverage
- Prior minimum essential group or individual coverage is required
- Dental or vision only coverage does not qualify to purchase medical coverage
- Documentation supporting the event and prior coverage is required within 30 days of enrollment
- ID cards from other carriers are not an acceptable for proof of prior coverage

Section 6: EVENTS REQUIRING MARKETPLACE OR STATE CONFIRMATION

6.1 Ineligible for APTC or Cost Share Reduction

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(b)(3)(i) 45 CFR 155.420(d)(6)(i) and (ii)
Description	• An enrollee or dependent is determined newly ineligible for Advanced Payment Tax Credit or Cost Share Reduction
Continuous Coverage	Blue Cross and BCN offers continuous coverage to individuals who lose a qualified health plan, including other carriers and apply within the SEP timeframe to avoid a gap in coverage. **If the applicant elects continuous coverage an effective date will be** • Day after the prior health plan termination date • Continuous coverage could result in retroactive premium
Special Enrollment Period	• May apply within 60 days after the date of event
Effective Date Option	• Event Date • 1st of the month following the date of application

- Must meet general and dependent eligibility requirements
- Allows for eligible dependent children in the enrollment
- May enroll for coverage or be added to an existing plan
- No prior coverage is required
- Each event must be submitted by the individual to the Marketplace for determination
- Documentation of the determination from the Marketplace granting a Special Enrollment Period is required within 30 days of enrollment

6.2 Material Violation

CFR	45 CFR 147.104(b)(2) 45 CFR 420(d)(5)
Description	• An enrollee or their dependent who adequately demonstrates to the Marketplace or the state that the plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the individual
Special Enrollment Period	• May apply within 60 days after the date of event
Effective Date Option	• An appropriate effective date determined by the marketplace

- Must meet general and dependent eligibility requirements
- Allows for other eligible dependent children in the enrollment
- May enroll for coverage or be added to an existing plan
- Each event must be submitted by the individual to the marketplace or state for determination
- Documentation of the determination from the marketplace or state granting a Special Enrollment Period is required within 30 days of enrollment

Section 6: Events Requiring Marketplace Or State Confirmation (continued)

6.3 Unintentional Enrollment or Non-Enrollment

CFR	45 CFR 147.104(b)(2) 45 CFR 155.420(d)(4)
Description	• An individual or dependent's enrollment or non-enrollment in a plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee or agent of the Marketplace or HHS, or a non-exchange entity providing enrollment assistance or conducting enrollment activities
Special Enrollment Period	• May apply within 60 days after the event
Effective Date Option	• An appropriate effective date determined by the marketplace

- Must meet general and dependent eligibility requirements
- Allows for other eligible dependent children in the enrollment
- May enroll for coverage or be added to an existing plan
- No prior coverage is required
- Each event must be submitted by the individual to the Marketplace or state for determination
- Documentation of the determination from the Marketplace or state granting a Special Enrollment Period is required within 30 days of enrollment
- If an error was made by an agent or employee of Blue Cross or BCN. See Exception Authority

Section 7: STAND ALONE DENTAL GUIDELINES

7.1 General Information: Stand Alone Dental, including Dental with Vision

Description	• An individual must be enrolled or actively enrolling in an individual or group medical health plan on On-Marketplace only. ○ This requirement does not apply to Off-Marketplace. • A Qualifying Life Event is not required to enroll • If termination of dental or vision is requested on a combined dental and vision plan, both dental and vision will be terminated The Affordable Care Act (ACA) requires issuers to ensure all members, regardless of age, obtain coverage that includes the ACA's 10 essential health benefit categories, one of which is pediatric dental benefits. Dental benefits, including pediatric benefits, are not packaged with Blue Cross or BCN medical plans. To satisfy the ACA requirements, Blue Cross or BCN enrollees or members will be offered: • A Blue Cross stand-alone all age dental plan with pediatric benefits, • A stand-alone pediatric only dental plan, or They may satisfy pediatric dental coverage with another issuer and provide an attestation of coverage to Blue Cross or BCN. See Pediatric Dental Attestation
Special Enrollment Period	• Follows the Qualifying Life Event guidelines
Effective Dates	• January 1, during the Annual Open Enrollment Period • Based on the event during the Special Enrollment Period
Effective Dates without an event	• Event date, or • 1st of the month following the date of application

- Must meet general and dependent eligibility guidelines
- An application is required to enroll, add or change dental plans
- Enrollment is accepted
  - During the Annual Open Enrollment Period
  - Special Enrollment Period due to a Qualifying Life Event
  - Off-Marketplace enrollment does not require a Qualifying Life Event
- A stand-alone dental plan change may be made
  - During the Annual Open Enrollment Period
  - Special Enrollment Period due to a Qualifying Life Event
- A child only policy enrollment is acceptable in the Blue Dental PPO Pediatric 80/50/50 plan
- See Stand-alone dental waiver of benefits

Section 7: Stand Alone Dental Guidelines (continued)

7.2 Loss of Marketplace Dental

Description	• An On-Marketplace individual lost comprehensive dental coverage
Continuous Coverage	Blue Cross and BCN offers continuous coverage to individuals who lose a qualified dental plan, including other carriers and apply within the SEP timeframe to avoid a gap in coverage. **If the applicant elects continuous coverage an effective date will be** • Day after the prior health plan termination date • Continuous coverage could result in retroactive premium
Special Enrollment Period	• May apply within 60 days prior or after the loss of dental coverage
Effective date for 60 days **prior** to loss of coverage	• Event Date, or • 1st of the month following loss of coverage
Effective date options for within 60 days **after** loss of coverage	• Event Date, • 1st of the month following application

- Must meet general and dependent eligibility guidelines
- Other eligible dependents may be included in the enrollment regardless of prior dental coverage

7.3 Part B Medicare Eligibility

Description	• An individual becomes newly eligible for Medicare part B • Must be enrolled in both parts A & B prior to applying
Continuous Coverage	Blue Cross and BCN offers continuous coverage to individuals who lose a qualified dental plan, including other carriers and apply within the SEP timeframe to avoid a gap in coverage. **If the applicant elects continuous coverage an effective date will be** • Day after the prior health plan termination date • Continuous coverage could result in retroactive premium
Special Enrollment Period	• May apply within 60 days prior or after of the Medicare part B effective date
Effective date for 60 days **prior** to loss of coverage	• Event Date, or • 1st of the month following loss of coverage
Effective date options for within 60 days **after** loss of coverage	• Event Date, or • 1st of the month following application

- Must meet general and dependent eligibility guidelines
- Other eligible dependents may be included with the individual experiencing the event
- An application is required to enroll or change a dental plan
- Submit a copy of their Medicare card which includes the part B effective date
- If the Medicare Part B effective date is greater than 60 days from the application receipt date, the individual may choose to enroll at the next Annual Open Enrollment Period, or first of the month following date of application if without an event

Section 7: Stand Alone Dental Guidelines (continued)

7.4 Pediatric Dental Guidelines

Description	• Members must be age 18 or younger on the effective date • Pediatric members are eligible to remain on a pediatric dental plan until the end of the calendar year in which they turn age 19

- When members no longer qualify for a pediatric plan at age 19, they may apply for other Blue Cross dental or dental with vision coverage within 60 days of the date their pediatric coverage ends or during the Annual Open Enrollment Period
- A dependent turning age 19 qualifies as an adult member and may
  - Enroll on a non-pediatric dental plan, or
  - Remain on a qualified dental plan with all age dental benefits. Premium will apply
- Blue Dental pediatric benefits are included in all Blue Cross stand-alone dental products

7.5 Pediatric Attestation

Description	• A dental attestation will be requested from enrollees and members under age 19 who do not have pediatric dental benefits with Blue Cross
	• The attestation verifies an enrollee or subscriber carries pediatric dental benefits or is enrolled in a qualified dental plan offering pediatric dental benefits with another carrier
	• A pediatric dental attestation is requested with
	  ○ New medical enrollment
	  ○ Medical plan changes
	  ○ Modifying an existing medical plan
	  ○ Renewing in a medical plan or placement into a new medical plan

Section 8: STAND-ALONE VISION GUIDELINES

8.1 General Information

Description	• Adult vision may be added to all other health plans or medical Off-Marketplace plans by purchasing a stand-alone vision plan
	• Stand-alone vision plan is only sold Off-Marketplace
	• The product has 2 different types of rates:
	  ○ Annual premium rate for a one-time payment for the year
	  ○ Monthly premium rate for ongoing monthly payments
	• Refunds are allowed by request provided no benefit utilization has taken place for which premium was paid
	• Stand Alone vision plan do not have pediatric vision benefits
	• Blue Vision benefits for pediatric members under age 19 are included in all Blue Cross or BCN health plans On and Off-Marketplace

8.2 Stand-Alone Vision Guidelines

Description	• Enrollees must be age 19 or older on the plan effective date
	• Off-Marketplace enrollment is accepted
	  ○ During the Annual Open Enrollment Period
	  ○ Special Enrollment Period with a Qualifying Life Event
	  ○ Any time throughout the year without a Qualifying Life Event

Special Enrollment Period	• Follows the Qualifying Life Event guidelines
Effective Dates	• January 1, during the Annual Open Enrollment Period • Based on the event during the Special Enrollment Period
Effective Dates without an event	• 1st of the month following the date of application

- Must meet general and dependent eligibility criteria, except for Medicare eligibility
- Medical coverage is not required to enroll
- Refunds are allowed by request provided no benefit utilization has taken place for which premium was paid
- Stand-alone vision plans are eligible for reinstatement
- Stand-alone vision plans do not have pediatric benefits, and are not available to pediatric members or for child only enrollment
- Vision benefits are not eligible for waiver

Section 9: COVERAGE CHANGES

Description	Existing Blue Cross or BCN members that change plans during the Annual Open Enrollment or Special Enrollment Period due to a qualifying life event • Plan changes between Off and On Marketplace are acceptable

- Existing members must continue to meet general and dependent eligibility requirements
- The last day of coverage in the prior plan will be the day before the effective date in the new Blue Cross or BCN plan when the change is made within 60 days
- An application is required when
  - Changing plans between carriers, Blue Cross and BCN
  - Changing plans between On and Off-Marketplace
  - A change in subscriber regardless of carrier change
- A change of status form may be used when changing an Off-Marketplace plan with the same subscriber, carrier and plan year

Section 10: CANCELLATION AND TERMINATION

10.1 General Information

Description	• **Cancellation** is an action that ends a member's enrollment on the date coverage otherwise would have become effective, resulting in coverage never having been effective with the issuer. The effect of the action would be that a member does not receive coverage from the issuer under that plan and the issuer would not be liable for covered services • **Termination** is an action taken after a coverage effective date that ends a contract on a date after the original coverage effective date resulting in a period during which the members were covered by the issuer

10.2 Death of a Subscriber

Description	Subscriber is the contract holder of the coverage

- Notification is accepted in writing or by phone
- Contract will be terminated as of the date of death
- Notification received greater than 6 months requires a death certificate
- The maximum period for a retroactive refund is 24 months
- Coverage ends for all members when the subscriber's contract is terminated
- Remaining members become qualified individuals for a Special Enrollment Period
- Off-Marketplace Blue Cross or BCN members may maintain the same Off-Marketplace plan without a gap in coverage
- Dependents may qualify for On-Marketplace coverage with Advanced Premium Tax Credit
- For coverage On-Marketplace, notification of death must go through the Marketplace

10.3 Free Look

MCL	MIC 500.3409
Description	Blue Cross and BCN Money back Guarantee

- If for any reason the subscriber wishes to cancel coverage, he or she must notify Blue Cross or BCN in writing or call customer service
- If the request to cancel coverage occurs within 10 days of the effective date, the subscriber will receive a refund of their premium and the contract will be voided from the effective date, resulting in not having issued any coverage
- If the request to cancel coverage occurs after the 10-day free look period, cancellation will follow the subscriber requested termination guidelines. The subscriber will receive a pro rata refund for the unexpired period
- For coverage On-Marketplace, request to cancel must go through the Marketplace

10.4 Grace Period Off-Marketplace

Description	The period after payment becomes due and before the policy is terminated

- For Off-Marketplace products and for members enrolled On-Marketplace but not eligible for Advanced Premium Tax Credit the grace period is 31 days from the premium due date
- If payment is not received by the end of the grace period, the contract will be terminated

Section 10: Cancellation and Termination (continuation)

10.5 Non-Payment of Premium Off-Marketplace

Description	Non-payment of premium will result in termination of the contract

- After the 31-day grace period Blue Cross or BCN will cancel the contract for non-payment
- All members on the contract will be terminated and coverage ends
- Termination for non-payment does not create a Special Enrollment Period. The subscriber and any members must wait until the Annual Open Enrollment Period, unless they experience a Qualifying Life Event
- Cancelled contracts will receive a termination for non-payment letter
- If the coverage was voided or terminated because of a duplicate enrollment, then the member must contact Blue Cross or BCN for reinstatement within thirty (30) days of the date the member's intended plan was cancelled
- An Off-Marketplace subscriber may be eligible for reinstatement. See Reinstatement

10.6 Plan is Discontinued or Decertified

CFR	45 CFR 147.106(c)(d) MIC 500.2213b(5), (6)
Description	Coverage that is discontinued or decertified by the Marketplace

- If Blue Cross or BCN discontinues a plan:
  - Blue Cross or BCN must provide notice in writing at least 90 calendar days before the date the coverage will be discontinued
  - Members would be eligible for a Special Enrollment Period in other Blue Cross or BCN plans for which they meet eligibility criteria, or with other issuers
- If Blue Cross or BCN discontinues all coverage:
  - Blue Cross or BCN must provide notice in writing at least 180 calendar days before the date the coverage will be discontinued
  - Members would be eligible for a Special Enrollment Period with other issuers

10.7 Rescission of Coverage

CFR	45 CFR 147.128
Description	Blue Cross or BCN Individual medical and dental coverage will be rescinded if the subscriber or authorized representative seeking coverage on the subscriber's behalf, has: • Performed an act, practice, or omission that constitutes fraud, • Made an intentional misrepresentation of material fact to Blue Cross or another party

- Coverage may be rescinded back to the effective date of the contract
- Blue Cross or BCN will provide notice to the subscriber at least 30 days prior to termination
- If permitted under the law, the subscriber and/or offender will be required to repay Blue Cross or BCN for payment of any services received during this period

Section 10: Cancellation and Termination (continuation)

10.8 Subscriber Newly Eligible for CHIP/Medicaid

Description	Subscribers or dependents who meet the eligibility guidelines for Children Health Insurance program or Medicaid and choose to enroll

- Contract termination requests are accepted from the subscriber only
- When notification is received within 60 days from the Medicaid or CHIP eligibility notification letter, Blue Cross or BCN will align the termination date to the day before the individual is determined eligible with supporting CHIP/Medicaid documentation
- When notification is received after 60 days from the date of eligibility or notification, Blue Cross or BCN may not end date the policy retroactively
- A subscriber does not have to cancel their off-marketplace coverage when becoming eligible for Medicaid. Note: Individuals with On-Marketplace coverage may no longer be eligible for APTC
- Remaining members become qualified individuals for a Special Enrollment Period

10.9 Subscriber Enrolls In Medicare

Description	Subscriber enrolls in Medicare and requests termination of their contract because he/she is no longer eligible or decided to enroll in a Supplement or Medicare Advantage plan

- Contract termination requests are accepted from the subscriber only
- If the subscriber of an Off-Marketplace contract enrolls in a Supplemental plan or Medicare Advantage product with Blue Cross, BCN or other carrier and requests termination of the individual plan within 60 days of the effective date, the termination date will line up with the effective date of the new Medicare contract
  - Requires proof of coverage with effective date from other carrier
  - Not applicable to enrollment in Medicare only or a Prescription Drug Plan (PDP) only
- If a subscriber of an Off-Marketplace stand-alone dental plan enrolls in a Medicare Advantage plan with the comprehensive dental buy-up option and requests termination within 60 days, the termination date of the stand-alone dental plan will line up with the effective date of the new Blue Cross or BCN Medicare Advantage contract.
- Remaining members become qualified individuals for a Special Enrollment Period
- Off-Marketplace members may maintain the same Blue Cross or BCN Off-Marketplace Individual plan without a gap in coverage. An application is required within the Special Enrollment Period timeframe.
- For coverage On-marketplace, request to cancel must go through the Marketplace

Section 10: Cancellation and Termination (continuation)

10.10 Redetermination of Subscriber Eligibility for Coverage

Description	Blue Cross or BCN may, at any time, review eligibility requirements for Off-Marketplace coverage in the Michigan plan

- Blue Cross and BCN will correspond with the Off-Marketplace subscriber and may request supporting documentation to validate eligibility for Michigan coverage based on the criteria in the general and dependent eligibility sections
- Blue Cross and BCN will provide notification of the redetermination decision
- If the subscriber is determined ineligible for Michigan coverage the policy will be cancelled, including any stand-alone dental or vision coverage
- The subscriber's last day of coverage is the last day of the month following the month in which the notice was provided by Blue Cross or BCN
- If the subscriber notifies Blue Cross or BCN they are no longer eligible, the policy will be cancelled and notification regarding their redetermination of eligibility is sent to the subscriber
- The spouse and dependents on the contract become qualified individuals if they continue to meet the general and dependent eligibility requirements
- Redetermination of On-Marketplace coverage will be done through the Marketplace

10.11 Subscriber Requested Termination

Description	Subscriber may request termination of an Off-Marketplace contract at any time

- Contract termination requests are accepted from the subscriber only
- The contract will terminate on a date requested by the subscriber no earlier than same day termination, if the request is beyond the initial free look period
- Retroactive termination dates are acceptable for death when permitted by law, or when the subscriber changes coverage with Blue Cross or BCN. See Coverage Change
- Retroactive terminations no greater than 60 days, are acceptable when the subscriber became eligible and enrolled in group coverage with Blue Cross, BCN or other carrier. Request must be within 60 days of the group coverage effective date.
  - Requires proof of coverage with effective date from other carrier
- All members on the contract will be terminated and coverage ends
- Termination of a stand-alone dental with vision plan ends both dental and vision coverage
- A subscriber who voluntarily terminates the contract may not be eligible to enroll until the next Annual Open Enrollment Period or Qualifying Life Event
- Eligible dependents currently enrolled on the subscriber's Blue Cross or BCN Off-Marketplace individual contract may choose to maintain the same Blue Cross, or BCN Off-Marketplace individual plan and align the effective date within 60 days of the termination. An application is required
- For coverage On-Marketplace, the request to terminate must go through the Marketplace

Section 11: TERMINATION OF DEPENDENTS

11.1 Attained Maximum Age Requirements

Description	Dependent children who reach the maximum age for dependent eligibility and are not certified as disabled will automatically be removed from the subscriber's Blue Cross or BCN medical coverage or Blue Cross pediatric dental only coverage at the end of the year they reach the maximum age.

- Maximum dependent age on a medical plan is 26
- Maximum dependent age on a pediatric dental only plan is 19
- The dependent becomes a qualified individual for a Special Enrollment Period and may apply for coverage within 60 days of the date they were removed
- Blue Cross or BCN will send notification that a dependent has become ineligible to remain on the medial or pediatric dental only coverage to the subscriber in accordance with the mandatory notices guidelines for renewal notifications 45 CFR 147.106
- Dependents turning age 19 continue to be eligible as a dependent on an all age dental plan

11.2 Dependent Termination Due to Death

Description	Death of a member other than the subscriber

- Notification is accepted in writing or phone
- The dependent will be terminated as of the date of death
- Notification greater than 6 months requires a death certificate
- The maximum period for a retroactive termination is 24 months from the date of death
- Any rate adjustments are effective as of the dependent removal date
- Any credit from a rating adjustment will be reflected on a future billing statement unless the subscriber requests a refund
- For On-Marketplace coverage, notification must go through the Marketplace

11.3 Subscriber Requested Dependent Termination

Description	A subscriber may request the removal of a dependent at any time. The request may be due to an event, or a voluntary action taken by the subscriber

- If the subscriber requests dependent removal the termination will occur on a prospective date requested by the subscriber, including same day notification
- Excludes retroactive termination, unless the termination is requested due to a dependent obtaining other health care coverage from a Qualified Life Event and notification is received within 60 days of the event. Termination is retroactive only to the date of the event.
    - Requires proof of coverage with effective date
- The dependent removed due to a Qualifying Life Event becomes a qualified individual and may apply for coverage within 60 days of the termination
- A dependent may not be added back to the subscriber's contract until the next Annual Open Enrollment Period, or unless they experience a Qualifying Life Event
- Dependents who were removed from a subscriber's Blue Cross or BCN Off-Marketplace individual contract without cause, may elect to maintain the same Blue Cross or BCN Off-Marketplace individual plan with an aligned effective date on their own contract. An application is required within 60 days from the removal date
- On-Marketplace coverage, the request to remove must go through the Marketplace

Section 12: OFF-MARKETPLACE REINSTATEMENT

Description	Reinstatement is a correction of an erroneous termination or cancellation action and results in restoration of effectuated medical, dental or vision coverage

Scenarios that qualify for reinstatement based on review and confirmation of error:

- **Erroneous Termination/Cancellation of an Enrollment by a Blue Cross, BCN, agent or broker**
  - The member was voided/terminated due to a Blue Cross or BCN file error
  - Payment was not applied correctly or timely by Blue Cross or BCN, resulting in termination
  - The member was provided incorrect information regarding payment due date and/or coverage Paid to Date
  - Coverage was voided/terminated because of a duplicate enrollment. Notification must be received within thirty (30) days of the date the member's intended plan was cancelled
- **Erroneous Death Notification**
  - Enrollee informs Blue Cross or BCN that they are not deceased and were terminated in error
- **Enrollee Cancellation of New Enrollment**
  - Enrollee's enrollment is terminated because the enrollee selected a different plan but then the enrollee cancels the selection of the new plan and the enrollee wants to remain in the previous plan
- **Off-Marketplace reinstatement** requests following non-payment of premiums will be considered provided the general eligibility guidelines and the following 2 conditions are met:
  - Requests received within 2 months from the paid to date
  - All past due premiums are paid in full to bring the policy up to date
- **Off-Marketplace reinstatements** more than two times in the same plan year, may be denied
- **On-Marketplace reinstatement** requests should go through the Marketplace

Section 13: RENEWABILITY

13.1 Guaranteed Renewability

CFR	45 CFR 147.106(a) and MCL 500.2213b 45 CFR 147.106(b) and 148.122(c) exceptions MIC 500.2213b(1),(4)
Description	Guaranteed Renewability requires Blue Cross and BCN to renew or continue in force coverage at the option of the member, including those eligible or entitled to Medicare and renew their existing coverage under the same contract number, unless one or more of the exceptions for non-renewal is met

- **Exceptions for non-renewals**
  - Non-payment of premium
  - Fraud
  - Termination/discontinuance of product
  - Movement outside of plan service area
  - Association membership ceases
  - Medicare Anti-duplication provision

Section 13: Renewability (continued)

13.2 Re-Enrollment and Plan Discontinuance

CFR	45 CFR 147.106
Description	A subscriber or dependent's ability to continue enrollment is subject to state and federal guaranteed renewability of coverage provisions Health insurance coverage in the individual market is required to be renewed or continued in force, at the option of the enrolled individual

- If a member is enrolled in an existing plan that will remain open or have limited changes (referred to as "uniform modifications") the following year, the member does not need to re-enroll for the next year
- If a member is enrolled in a plan that will be discontinued, Blue Cross or BCN would move the member into a new plan within the same product, if one is available. Except in situations covered under the Medicare Anti-Duplication Provision
- If there is no plan available within the same product line, and the plan is not a silver plan, the member needs to apply for new coverage. If a silver plan closes, and a silver plan is available in another product, the members in the closing silver plan will be switched to the silver plan that is remaining open
- Members previously On-Marketplace may be moved to Off-Marketplace coverage if they are considered an "unaffiliated enrollment," which results from a discrepancy between Marketplace and Blue Cross or BCN enrollment data

Section 14: EXCEPTION AUTHORITY FOR SALES

Description	• Individual Sales Support and the sales team are hereby granted the authority to review and approve exceptions deemed necessary as corrective action on the Off-Marketplace member's behalf based on established business rules and requirements • Approved exceptions will be sent through the established channels to the appropriate membership and billing areas at Blue Cross or BCN for processing with no further review requested • If agents are unsure how to submit an exception request, they can contact their Individual Sales Consultant • This applies to Off-Marketplace only

Appendix A: DEFINITIONS

Actuarial Value is an estimate of the percentages of total cost of benefits that is aid by the health plan

Advanced Premium Tax Credit (APTC) is an income-based subsidy provided to an eligible individual enrolled in a qualified heath plan through the exchange

Affordable Care Act (ACA) is made up of two bills to form the National Health Care Reform Law.

- Patient Protection and Affordable Care Act (PPACA, Pub. L. 111-148) signed into law by President Obama March 30, 2010 and went into effect January 1, 2014.
- Health Care and Education Reconciliation Act (Pub. L. 111-152) signed into law March 30, 2010

Ancillary Products are stand-alone products, dental and vision, that are not packaged with Blue Cross or BCN health plans or medical plans and can be purchased in addition to the medial plan

Annual Open Enrollment Period is the period during which an eligible individual may enroll in coverage, change coverage, or add and delete members without a Qualifying Life Event

Applicant is the person who applies or requests coverage

Catastrophic coverage meets all the requirement for a qualified health plan but does not cover benefits before the plan's deductible is met

Certificate is a document that describes an enrollee and dependents benefit plan and any riders that amend the certificate

Code of Federal Regulations (CFR) is the codification of general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government

Contract includes the certificate and any riders, a signed application for coverage and the Blue Cross or BCN identification card

Department of Insurance and Financial Services (DIFS) is the State of Michigan department that regulates insurers in Michigan

Effective Date is the date coverage begins under the contract and is established by Blue Cross or BCN, pursuant to regulatory requirements

Effectuated Contract means the contract is active and the member is considered to have accepted the terms and conditions of the contract

Eligibility refers to meeting the requirements set forth by the Affordable Care Act, Michigan Compiled Laws, Blue Cross and BCN to properly obtain insurance

Essential Health Benefits are the 10 categories of benefits established by the Affordable Care Act that individual health plans must offer

Foster Child is a child legally raised by someone who is not his or her natural or adoptive parent

Group Health Plan means an employee welfare benefit plan that provides medical care to employees and their dependents directly or through insurance.

- Applicable to former employees or retires
- Excludes a Health Reimbursement Arrangement with a qualified small employer

Guaranteed Renewability requires Blue Cross and BCN to renew or continue in force coverage at the option of the member, including those entitled to Medicare and renew their existing coverage under the same contract number. There are exceptions for non-renewal

Appendix A: Definitions (continued)

Health and Human Services Department (HHS) is one of the United States Department departments of the United States government responsible for regulating health insurance, with primary responsibility for regulating the market wide and Marketplace requirements

Mandatory Notices are required as part of the guaranteed renewability guidelines in the Affordable Care Act and are specific to discontinuance and renewals

Marketplace or Exchange is a government agency or non-profit entity that reviews qualified health plans and makes them available to enrollees as specified under the Affordable Care Act

Michigan Complied Law (MCL) is the official codification of statutes for the state of Michigan

Medically Needy Medicaid Coverage (often referred to as a "spend-down" program) is Medicaid coverage for medical expenses incurred after an individual, with an income otherwise too high for Medicaid eligibility, has spent enough on medical expenses to qualify for Medicaid [42 U.S.C. 1902(a)(10)(C)]

Member means subscriber and any eligible dependents listed on the application who enroll and active insurance coverage

Michigan Compiled Laws are the compilation of state laws, including those regulating the business of insurance

Network a group of facilities, providers and suppliers a health carrier contracts with to provide healthcare

Plan Year is a calendar year, January 1 to December 31

Pregnancy Related Medical Coverage

- Coverage the state must provide for women during and 60-days following pregnancy, and for infants under one year of age, whose family income does not exceed the minimum income level the State is required to establish for such a family [42 USC 1396a(a)(10)(A)(i)(IV)]
- Coverage the state may choose provide for women during and 60-days following pregnancy, infants under one year of age, children who have attained one year of age but have not attained 6 years of age, and children born after September 30, 1983 (or, at the option of a State, after any earlier date) who have attained 6 years of age but have not attained 19 years of age, whose family income does not exceed the income level established by the State and who are not covered under mandatory coverage [42 USC 1396a(a)(10)(A)(ii)(IX

Qualified Health Plan Insurer a health insurance carrier that offers Qualified Health Plans in accordance with a certification from the Marketplace. Blue Cross and BCN are Qualified Health Plan issuers

Rescission is the retroactive cancellation of coverage to the original effective date of coverage due to an act, practice or omission that constitutes fraud or intentional misrepresentation

Subscriber is the person for whom the application is submitted and whom the individual policy is issued

Summary of Benefits and Coverage (SBC) is an overview of coverage information required by the ACA to provide an easy to read summary of benefits, coverage and cost that can be used for comparison when selecting a health plan

Travelers defines how deductibles, co-pays, coinsurance and benefit maximums accumulated by a member during a given calendar year “travel,” or stay, with the member when the contract size changes

Appendix B: ON-MARKETPLACE EVENTS

Citizenship: An individual who becomes newly eligible for enrollment in a QHP through the Exchange because he/she gains status as a citizen, national, or lawfully present [45 CFR 155.420(d)(3)]

Incarceration: An individual becomes newly eligible for enrollment in a QHP through the Exchange because he/she is released from incarceration [45 CFR 155.420(d)(3)]

Newly eligible for APTC or change in eligibility for CSR: An individual or his/her dependent currently enrolled in an On-Marketplace plan and is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions [45 CFR 155.420(d)(6)(i) and (ii)]

Cost Share or APTC Change while eligible for group: An individual or dependent who is enrolled in an eligible employer sponsored plan is determined newly eligible for advanced payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer sponsored plan that meets minimum value and affordability standards, including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, providing that such individual is allowed to terminate existing coverage [45 CFR 155.420(d)(6)(iii)]

Newly Eligible for APTC after Being in the Expansion Gap: A qualified individual previously ineligible for APTC solely because of a household income below 100% FPL and ineligible for Medicaid during that same time because they lived in a non-Medicaid expansion state and who is newly eligible for APTC due to 1) a change in household income or 2) a move to a non-Medicaid expansion state [45 CFR 155.420(d)(6)(iv)]

Monthly Low-Income Special Enrollment Period:
The rule finalizes the monthly special enrollment period (SEP) for consumers with income no greater than 150% of FPL for periods when their applicable percentage is set at zero.
[45 CFR 155.420(d)(16)]

Native American or Alaskan Native: Native American and Alaskan native enrollment changes are allowed once per month for subscriber and dependents [45 CFR 155.420(d)(8)]

Exceptional Circumstances: As determined by the Marketplace [45 CFR 155.420(d)(9)]

Plan and benefit display errors: The individual, or his/her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP through the Exchange [45 CFR 155.420(d)(12)]

Data Matching: A consumer resolves a data matching issue following the expiration of an inconsistent period [45 CFR 155.420(d)(13)]

Appendix C: ON-MARKETPLACE GRACE PERIOD

The grace period is a period of time after the payment due date. For on-marketplace individuals who receive advanced payment of the premium tax credit (APTC), there is a 3-month grace period on an effectuated contract

- If payment is not received the contract will be terminated
- On-Marketplace members are allotted the full 3-month grace period, even if they lose APTC eligibility during this time
- After the appropriate grace period and proper notification, Blue Cross and BCN will terminate the contract for non-payment

Appendix D: ON-MARKETPLACE NON-PAYMENT OF PREMIUM

When a contract terminates for non-payment of premium all existing members will be terminated, and the coverage ends.

- Termination for non-payment does not create a Special Enrollment Period
- The subscriber and any members must wait until the Annual Open Enrollment Period, unless they experience a Qualifying Life Event
- All premium statements and delinquency notices include a message that states the contract will be terminated if the premium is not paid within grace period rules
- A final bill will be sent to further notify of pending termination
- Cancelled contracts will receive a termination for non-payment letter

Note: Claims for services rendered in the second and third months of the grace period may be pended until all outstanding premiums are paid. If this grace period has been exhausted and the subscriber has not paid all outstanding premiums, the termination date for this event would be last day of the first month of the 3-month grace period.

Appendix E: STAND ALONE DENTAL WAIVER OF BENEFITS

Stand-alone dental plans have a benefit waiting period for Class II and Class III services

- The benefit waiting period must be met before dental benefits for Class II and Class III services are paid unless the waiver eligibility rules are met

Waiver General Information

- Class II waivers require 6 months of prior comprehensive dental coverage
- Class III waivers require 1 year of prior comprehensive dental coverage
- Comprehensive dental coverage is dental coverage that includes Class III services
- All dental waiting period waivers are based on a lapse in coverage within 60 consecutive days
- If the lapse is greater than 60 consecutive days, the member is not eligible for a waiver, except for months with 31 days
- Eligible coverage for waiver: prior group or individual dental coverage must be a comprehensive dental plan or a Medicare Advantage plan with the comprehensive dental buy-up option
- Pediatric Dental is considered comprehensive dental and qualifies for review of waiver
- Non-comprehensive dental plans do not qualify for waiver
    - Medicare Supplemental dental, vision and hearing package buy-up options are not comprehensive dental plans and do not qualify for waiver
- Medicare Advantage members who choose a commercial dental plan are not eligible for waiting period waiver
- The subscriber and dependents of the previous plan are each eligible for review of the dental waiver of benefits and may enroll separately
- If the waiver is granted, the waiver of the dental benefits waiting period will apply to all members on the contract, regardless if they were on the prior plan
- **There are no partial waivers**. Example: Four months of prior comprehensive coverage will not reduce Class II waiting period or eight months of prior comprehensive coverage will not reduce Class III waiting periods
- Members must submit supportive documentation including length of coverage to be reviewed for Class II or Class III benefit waiting periods
- All requests for waiting periods to be waived with proof of prior comprehensive dental coverage send to DirectBilledMembership@bcbsm.com

Waiver: BCBSM/BCN Group to Blue Cross Individual

- **If the member satisfied their dental waiting period under an existing Blue Dental group plan;** they are eligible for waiver of the new individual Blue Dental waiting period
- **If the member satisfied part of their dental waiting period under an existing Blue Dental group plan**; the member is not eligible for waiver of their dental waiting period
- **If there is a lapse in coverage within 60 days with the exception during months with 31 days;** the member is eligible for waiver based on the coverage in their previous Blue Dental plan
- **If the lapse in group coverage is greater than 60 days with the exception during months with 31 days;** the member is not eligible for a waiver of their dental waiting period
- **If the group plan provided limited, non-comprehensive dental coverage;** the member is not eligible for a waiver of their dental waiting period
- **If the medical plan did not include comprehensive dental coverage;** the member is not eligible for a waiver of their dental waiting period

Appendix E: Stand Alone Dental Waiver Of Benefits (continued)

Waiver: Other Carrier Group or individual to Blue Cross Individual

- Creditable documentation of the prior group or individual comprehensive dental coverage is required for review of the benefit waiting period
- **If the previous dental plan was an employer sponsored group or individual comprehensive dental plan**, the contract is eligible for waiver of the new individual Blue Dental waiting period
- **If the previous employer sponsored group dental or an individual comprehensive dental plan's end date was within 60 days from the new individual Blue Dental plan's effective date,** the contract is eligible for waiver of the individual Blue Dental waiting period
- **If the lapse in coverage is greater than 60 days, with the exception during months with 31 days**, the contract is not eligible for waiver of the individual Blue Dental waiting period
- **If the member's previous plan was a group or an individual plan in a state other than Michigan**, the contract is eligible for waiver of the individual Blue Dental waiting period
- **If the employer sponsored group plan or individual dental plan was pediatric-only or was not a comprehensive dental plan**, the contract is not eligible for waiver of the individual Blue Dental waiting period

Waiver Blue Cross Individual to Blue Cross Individual

- **If the member satisfied their dental waiting period under an existing Blue Dental plan**, they are eligible for waiver under the new Individual Blue Dental plan
- **If the member satisfied part of their dental waiting period under an existing Blue Dental plan**, the member is not eligible for waiver of the dental waiting period.
- **If there is a lapse in coverage within 60 days with the exception during months with 31 days**, the member is eligible for waiver based on coverage in their previous Individual Blue Dental plan
- **If the member's previous plan was an individual Blue Dental plan in a state other than Michigan**, the member is eligible for waiver of the dental waiting period

Appendix F: CARRYOVER AND TRAVELERS

Carryover

BCBSM and BCN carryover out-of-pocket totals guidelines (as of March 2021). A carryover is the money paid toward the out-of-pocket totals that is transferred from one plan to the next. Totals are out-of-pocket maximums, such as deductibles and copayments, that apply to each plan.

- **IBU BCN** plan totals **do** transfer automatically:
  - Between all BCN individual plans.
  - Between all BCN group plans.

- **IBU BCBSM** plan totals **do** transfer automatically:
  - Between all BCBSM individual plans.

- **Between IBU** BCBSM and BCN plans.
  - Upon Request

- **Between group** BCBSM plans to **individual** BCBSM and BCN plans
  - Upon Request

- **Between group** BCN plans to **individual** BCBSM plans
  - Upon Request

- Totals **do not** transfer:
  - From other issuers to IBU BCBSM and BCN plans.
  - Fourth quarter deductibles from one year to the next.

- Totals (deductible only) **do** transfer from BCBSM and BCN individual plans to MA plans.

Note: Benefit limits restart when a member switches to a new plan or metal tier.

To submit prior accumulator transfer request please go to:
Corporate Prior Deductible Carryover

Appendix F: Carryover and Travelers (continued)

Travelers

Travelers defines how deductible and percent co-pays (coinsurance) and benefit maximums accumulated by a member during a given calendar year travel with the member when the contract size changes due to a Qualifying Life Event and the member stays with the same issuer.

The deductible and percent co-pays (coinsurance) accumulated by an individual travel with the individual member, whether going from family to single or single to a family contract. This applies only to an individual traveling within the same issuer for individual under 65 plans. Benefits will be paid by Blue Cross or BCN in accordance with the terms of the applicable product certificate.

- If a single contract adds a baby, the contract is now a family contract and the family deductible must now be met
- If a single subscriber meets a single contract deductible, but the contract becomes a family contract during the calendar year, the remainder family deductible must be met by the rest of the members
- If a family contract becomes a single contract due to divorce or age-off of the subscriber or member, the deductible and percent co-pays (coinsurance) accumulated by the subscriber or member stay with that subscriber or member and travel to the new individual under 65 contracts within the same issuer
- If a family contract becomes a single contract due to death of the subscriber, spouse or dependent member, all deductibles coinsurance and co-pays accumulated within the family contract (including the member that died) travel with the family to the new under 65 plan, within the same issuer
- If a family contract must be rewritten as a new family contract because the subscriber dies, any deductible and percent co-pay (coinsurance) accumulated by the members on the original family contract will travel within the same issuer, as a rewritten contract for those younger than 65
- If a family contract must be rewritten because the subscriber or member ages off to a 65+ plan, the deductible accumulated by the subscriber or member who enrolls in a 65+ plan travels to the new 65+ MA plan, precent co-pay (coinsurance) does not travel to the new 65+ MA plan. In addition, the percent co-pay (coinsurance) accumulated by the subscriber or member who enrolls in the 65+ plan do not travel with the under 65 members to a new under 65 contracts. The percent co-pays (coinsurance) accumulated by the under 65 members on the old family contract will travel with those members within the same issuer on the new under 65 family contracts