Section 2: Eligibility

Subscriber eligibility

Eligible subscribers are individuals in your organization who qualify for coverage under your group health care plan. To establish a group health care plan for an organization, an “employee-employer” relationship must exist. An employer-employee relationship exists when all of the following requirements are met:

- An employer/employee relationship exists with respect to participants in the group health plan. Employees must perform services for the employer, and the employer has the right to control the detail of how the services are performed. Enrollees will also include retirees and former employees eligible for COBRA.
- Only those classes or segments of employees identified in the Summary Plan Description (SPD).
- The employer withholds payroll taxes on wages paid to employees.
- The employer contributes to the Michigan Unemployment Insurance trust fund for employees.
- The employer provides workers’ compensation insurance for employees as required by law.
- The employer must be headquartered in Michigan and have a unique Michigan tax identification number.

If this relationship exists and the individual meets the other requirements in this section, the individual is eligible to enroll for health care coverage.

Owners, proprietors and employers

Business owners, proprietors and employers are eligible for your health plan if they:

- Have a direct and active interest in the organization.
- Have a direct voice in all major decisions affecting the organization.
- Report at least once a week to the place of business.
- Receive their major source of earned income from the organization.

Full-time workers

Individuals are considered full time if they work an average of 30 hours per week and have permanent work. The number of hours may vary depending on your personnel policy. Full-time workers have payroll deductions for Social Security and federal income tax and are eligible for all other fringe benefits offered by your organization. Generally, all full-time workers are eligible for coverage. See your Group Enrollment and Coverage Agreement for any other requirements that might apply.
Section 2: Eligibility

Part-time workers
An individual who works fewer hours than the hours you require for a full-time worker is considered part-time. Generally, part-time workers are not eligible for health care coverage unless your Group Enrollment and Coverage Agreement extends coverage to them. However, they must also have payroll deductions for Social Security and federal income tax (if applicable), and be eligible for all other benefits offered by your organization.

Seasonal workers
These are individuals who regularly work only a portion of each year because the nature of the business is affected by the season. They are eligible only when they work for at least nine months out of the year. The worker must have payroll deductions for Social Security and federal income tax and receive all other benefits available to full-time workers. This period should be consistent in terms of the length of time the employee works each year and the time of year the employee is normally recalled to work. They must also have payroll deductions for Social Security and federal income tax (if applicable), and be eligible for all other benefits offered by your organization.

Retirees
A retiree segment consists of the enrolled, eligible retired employees of an employer/employee group customer. The retiree segment must adhere to all group eligibility requirements, as well as meeting the following requirements:

- Retiree Group Health Plan complies with ERISA of 1974 as amended, HIPAA and the Internal Revenue Code, or other applicable laws.
- The terms of this Retiree Group Health Plan have been set forth in a Summary Plan Description and distributed to all employees.
- You must maintain a corresponding active segment with a minimum of five active, non-retiree, non-COBRA, medical contracts (employees) enrolled with BCBSM.
- No separation of Medicare and non-Medicare retirees between carriers except when the group offers a BCN group Medicare Advantage plan.
- Provide minimum years of service required, minimum retirement age and employer contribution amount in the BCBSM Retiree Agreement.
  - BCBSM reserves the right to request a copy of:
    - Summary Plan Description, as required by the Department of Labor
    - Retiree Group Health Care Plan document
    - Section 125 Cafeteria Plan document
    - Union contract
Section 2: Eligibility

- BCBSM will consider enrolling a retiree segment from a collective bargaining agreement, when either segment, union or non-union, is not offered BCBSM coverage through the employer group health plan.

- An employer must contribute a minimum of 50 percent of the retiree’s health care premium. Reform groups of 2 – 50 eligible employees are not subject to the 50-percent minimum employer contribution requirement.

- The level of benefits offered to the retiree segment of a group must not exceed the highest benefit plan offered to the corresponding active segment, unless otherwise mandated by a union agreement.

- **Employee eligibility**
  - Only those employees eligible pursuant to the terms of the Employer’s Retiree Health Plan may enroll in the Retiree Health Care Program. These employees must meet BCBSM underwriting guidelines and all eligibility requirements detailed in the plan document. They also must have been covered previously in the BCBSM active segment immediately prior to being eligible for retiree coverage.
  - Enrolled retirees must be transferred from the active segment to the retiree segment at the time they become eligible for retiree benefits.
  - Any retiree who is eligible for Medicare Parts A and/or B, whether enrolled or not, must enroll in BCBSM Medicare Supplemental coverage. BCBSM coverage will be secondary to Medicare.

- **Owner eligibility**
  - Former owners are not eligible unless they meet the retiree eligibility requirements of the existing retiree segment and are enrolled in the retiree segment prior to selling the business.
  - If a change in ownership occurs, BCBSM may review the group and retiree segment to ensure current eligibility requirements are met. BCBSM is not bound by the terms of a purchase agreement between owners.

**Retiree segment cancellation**
A retiree segment will be cancelled if there are no remaining active segments enrolled with BCBSM, or the employer is no longer in business.
Section 2: Eligibility

Surviving spouse eligibility requirements

- If your plan permits the surviving spouse of a retiree to continue health care benefits, they may remain enrolled as long as all the following guidelines are met:
  - You must elect a surviving spouse option with BCBSM and provide required documentation to establish surviving spouse benefits.
  - The retiree must have been eligible and enrolled in the program at the time of death.
  - Your organization contributes a minimum of 50 percent of the surviving spouse’s health care premium. Note that reform groups are not subject to the 50 percent minimum employer contribution requirement.
  - You collect any contributions due from the surviving spouse and remit total premium to BCBSM.

Surviving spouses eligible for Medicare Parts A or B, whether enrolled or not, must enroll in BCBSM Medicare Supplemental coverage. BCBSM coverage will be secondary to Medicare.

Note that surviving spouse coverage may remain in effect only as long as the group meets all BCBSM underwriting eligibility requirements.

The following exclusions apply to surviving spouse coverage:

- Does not include a person who marries a member with surviving spouse coverage.
- Surviving spouses who waive their health care coverage are no longer eligible for surviving spouse coverage.

Exclusions for subscriber eligibility

The following employees are not eligible for coverage:

- Temporary workers hired for a limited period without guarantee of rehire or recall at the end of that period.
- Students-in-training and “co-ops.”
- Independent contractors and commissioned personnel who don’t meet criteria for an employer-employee relationship.
Dependent Eligibility

Individuals who enroll for health care coverage through your group may also enroll their eligible dependents. A dependent is no longer eligible for coverage when the subscriber ceases to be eligible or enrolled for coverage. Dependents can include:

1. Spouse
A subscriber’s spouse is the legally married husband or wife of the subscriber

2. Domestic partners
Includes coverage for a subscriber’s same-gender domestic partner and dependent children of the partner when your organization includes the domestic partner rider in its coverage. Underwritten groups that are public employers, such as governments and school districts, are not eligible for the domestic partner rider.

Groups are required to consult their own legal counsel regarding the legality of coverage for same-sex domestic partners and their children. Blue Cross Blue Shield of Michigan does not represent that any group health plan design complies with Michigan law.

If your group is eligible for the domestic partner rider, all of the following requirements must be met:

- The domestic partners are 18 years of age or older.
- Neither domestic partner is legally married.
- The domestic partners are not related by blood in a manner that would bar legal marriage if they were not of the same gender.
- The domestic partners have lived together for the past 12 consecutive months. The subscriber must furnish BCBSM with proof that the subscriber and domestic partner have lived together for this period of time. Proof may be established by a rental or mortgage agreement, driver’s license, student identification, voter registration card or document showing city or county registration. Other documentation may be accepted.
- A signed and notarized Affidavit of Domestic Partnership is submitted to BCBSM with the Change of Status form (page 6) located in the Enrollment Change of Status (CF 3599) document.
Section 2: Eligibility

Coverage for a domestic partner takes effect 90 days after the application is approved by BCBSM.

Under certain conditions, groups that select the domestic partner rider can have the 90-day waiting period for domestic partners and their children waived at the group’s initial enrollment. A waiver will be allowed only for partnerships that existed at the time BCBSM coverage becomes effective. The domestic partner must demonstrate that he or she, and applicable dependents, had coverage under your former insurance carrier for at least 90 days prior to your group’s effective date of BCBSM coverage. The partner or partner and his or her children must meet all eligibility requirements, including completion of a signed and notarized Affidavit of Domestic partnership.

BCBSM will also waive the 90-day period for domestic partners and their children who are no longer eligible for coverage under another health plan to comply with portability rights under HIPAA. The domestic partner’s former employer or insurance carrier must document that the domestic partner is no longer eligible for coverage and the domestic partner and children must meet all other eligibility requirements, including completion of a signed and notarized Affidavit of Domestic Partnership. The request to add a dependent must be made within 30 days of loss of eligibility for the other coverage.

Termination of domestic partner benefits

Coverage for the domestic partner and his or her dependent children ends when the subscriber requests removal of the domestic partner from contract; the subscriber’s coverage ends; or the domestic partnership ends.

- If the subscriber removes his or her domestic partner from the contract, either a new domestic partner or previous domestic partner cannot be added to the contract until all of the eligibility requirements are met, and one year has elapsed from the date of removal of the previous domestic partner.
- The new domestic partner can be added the first billing cycle 90 days after the date the application is approved.
- A domestic partner who is removed from a contract may be eligible for group conversion.
- COBRA coverage is not available to domestic partners or their dependent children. If the domestic partner is removed from the subscriber’s contract, the domestic partner’s children will also be removed.
- Domestic partners are not eligible for surviving spouse coverage.
3. Dependent children**
This category includes children of the subscriber or spouse by birth, marriage, legal adoption or legal guardianship. To enroll a child who is the subject of a guardianship, a copy of the court order appointing guardianship must be submitted with the request to add the dependent. A child may enroll prior to granting of guardianship if the subscriber has filed a petition for guardianship and the child resides with the subscriber (copy of petition required).

**PPACA compliant groups:**
Dependent children are eligible for coverage through the end of the calendar year in which they turn age 26 provided the child is related to the subscriber or subscriber’s spouse by birth, marriage, legal adoption or legal guardianship.

**PPACA exempt and deferral groups***:
- Dependent children are eligible for coverage through the end of the calendar year in which they turn age 19 provided the child is unmarried and related to the subscriber or subscriber’s spouse by birth, marriage, legal adoption or legal guardianship.

Note: Grandchildren (unless qualified under legal guardianship) and the spouse of a dependent child are not eligible for coverage under the subscriber’s contract for either PPACA compliant or exempt and deferral groups.

4. Dependent children of domestic partners**

**PPACA compliant groups:**
- Dependent children are eligible for coverage under the subscriber’s contract through the end of the calendar year in which they turn age 26, and must be related to the domestic partner by birth, legal adoption or legal guardianship.

**PPACA exempt and deferral groups***:
- Dependent children are eligible for coverage under the subscriber’s contract through the end of the calendar year in which they turn age 19. They must also meet the following requirements:
  - Related to the domestic partner by birth, legal adoption or legal guardianship.
  - Unmarried.
  - Domestic partner dependents as defined under the United States Internal Revenue Code.
  - Claimed as exemptions on the domestic partner’s tax return.
  - Reside with the subscriber and domestic partner. If the dependents do not reside with them, the medical care for the children must be the domestic partner’s legal responsibility.
  - Dependent on the domestic partner for more than half of their support.

Note: Grandchildren (unless qualified under legal guardianship) and the spouse of a dependent child are not eligible for coverage under the subscriber’s contract for either PPACA compliant or PPACA exempt and deferral groups.
Section 2: Eligibility

5. Disabled children of domestic partners children of the domestic

PPACA compliant groups:
Disabled, unmarried children of the subscriber’s domestic partner may remain
covered under the subscriber’s contract beyond the end of the year in which
they turn age 26 if they meet all of the following eligibility requirements:

- Totally and permanently disabled due to a physical condition or mental
  retardation.
- Incapable of self-sustaining employment.
- Disability began before their 19th birthday.
- Physician certification verifying the child’s disability and that it occurred
  prior to their 19th birthday must be submitted to BCBSM by the end of
  the calendar year in which the child turns age 26.
- Receive more than half of their support from the domestic partner.
- Reported as a dependent on the domestic partner’s most recent federal
  income tax return.

PPACA exempt and deferral groups*:
Disabled, unmarried children of the subscriber’s domestic partner may remain
covered under the subscriber’s contract beyond the end of the year in which
they turn age 19 provided they meet all of the same eligibility requirements
listed under PPACA compliant groups.

- Physician certification verifying the child’s disability and that it occurred
  prior to their 19th birthday must be submitted to BCBSM by the end of
  the calendar year in which the child turns age 19.

Note: A dependent whose only disability is a learning disability or substance
abuse does not qualify for coverage as a disabled dependent under Section 410
of Public Act 350 either for PPACA compliant or exempt and deferral groups.

6. Principally supported children
Principally supported children are no longer eligible for coverage for new
groups with effective dates of Jan. 1, 2011 and after. Existing groups may
retain their principally supported members, but may not add any new members
beginning Jan. 1, 2011.
A principally supported child is defined as a child related to the subscriber by blood or marriage. The child must also meet all the following requirements:

- Younger than 19 years of age and unmarried.
- Legally resides with the subscriber.
- Not Medicare eligible.
- Reported as a dependent on the subscriber’s most recent federal income tax return. If the child began living with the subscriber after the last tax filing, the child must qualify in the current tax year for dependency status.
- Principally supported by the subscriber for a minimum of nine consecutive months before coverage is effective.

### 7. Disabled children

**PPACA compliant groups:**

Disabled, unmarried children may remain on the subscriber’s contract beyond the end of the calendar year in which they turn age 26 if they meet all the following requirements:

- Diagnosed as totally and permanently disabled due to a physical condition or mental retardation.
- Incapable of self-sustaining employment.
- Disabled prior to age 19.
- Receives more than half of his or her support from the subscriber.
- Reported as a dependent on the subscriber’s most recent federal income tax return.
- Physician certification verifying the child’s disability and that it occurred prior to their 19th birthday must be submitted to BCBSM by the end of the calendar year in which the child turns age 26.

**PPACA exempt and deferral groups**:  

Disabled dependent children may remain on the subscriber’s contract beyond the end of the calendar year in which they turn age 19 if they meet all of the same eligibility requirements listed under PPACA compliant groups.

- Physician certification verifying the child’s disability and that it occurred prior to their 19th birthday must be submitted to BCBSM by the end of the calendar year in which the child turns age 19.

**Note:** A dependent whose only disability is a learning disability or substance abuse does not qualify for coverage as a disabled dependent under Section 410 of Public Act 350 either for PPACA compliant or PPACA exempt and deferral groups.
Section 2: Eligibility

8. Family continuation and dependent continuation rider coverage
Available to PPACA exempt and deferral groups only*:
Family Continuation (FC) and Dependent Continuation (DC) rider coverage is
not PPACA compliant and only available to the following groups:

- Groups with stand alone dental or stand alone vision (no medical
  coverage with BCBSM or BCN) with the DVC-FC rider
- Groups with the medical FC or DC rider that qualify for and elect
deferral of the near-term benefit mandates under PPACA.
- Retiree-only groups with medical FC or DC rider that choose not to
  implement PPACA near-term benefits as permitted under the law.

Under these riders, coverage for dependent children is extended through the
end of the calendar year in which they turn age 25, provided the subscriber
continues to be enrolled and eligible for coverage and the dependent child meets
the following requirements:

- Between the ages of 19 and 25.
- Unmarried.
- Resides with the subscriber unless he or she resides somewhere else
temporarily.
- Subscriber provides more than half of the child’s support.
- Related to the subscriber by birth, marriage, legal adoption or legal
  guardianship.
- Full-time students for a minimum of five months each year or has gross
income of less than four times the personal exemption amount identified
under federal law.

BCBSM will continue coverage when a student takes a leave of absence from
school or changes to part-time status due to a serious illness or injury. The
continuation of coverage will last for up to one year after the first day of a
medically necessary leave of absence (or change to part-time status) or the date
on which coverage would otherwise be terminated, whichever is earlier.

To qualify for continued coverage, the student’s attending physician must certify
in writing that the student’s leave or change to part-time status is medically
necessary and due to a serious illness or injury. BCBSM may require a copy
of the certification upon request. The student must continue to meet all other
BCBSM eligibility requirements for dependent continuation coverage.
9. Sponsored dependent coverage rider
Provides coverage for dependents of the subscriber when the group selects the rider and the dependent meets all of the following requirements:

- Over 19 years of age.
- Not eligible for coverage as a regular dependent, or under the medical Family Continuation or Dependent Continuation riders.
- Legally resides with the subscriber.
- The subscriber provides more than half of the dependent’s support.
- Qualified as a dependent on the subscriber’s last tax return filed under the Internal Revenue Code of the United States.
- Related to the subscriber by blood, marriage or legal adoption.

Sponsored Dependents enrolled with Medicare must enroll with Medicare supplemental coverage unless the group’s coverage is required to be primary under the Medicare Secondary Payer laws.

Note: The Sponsored Dependent rider is only available to ERS groups with 100+ enrolled medical contracts and ASC groups.

Additional information on the PPACA can be found at bcbsm.com/healthreform.

*PPACA exempt and deferral groups include:
- Groups with stand alone dental or stand alone vision coverage.
- Retiree-only groups that choose not to implement PPACA near-term benefits as permitted under the law.
- Groups that qualify for and elect deferral of the near-term benefit mandates under PPACA.

Deferral groups must comply with PPACA by their plan year effective date on or before Sept. 22, 2011.

**These represent standard rules that may vary depending on the customer.