

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:

- There exists an employer/employee relationship with respect to participants in the group health plan, or GHP. 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 or GHP may enroll for BCBSM coverage.
- 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.

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 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.

Retirees

Retirees and their eligible dependents are eligible to continue their health care coverage only if your organization has an established retiree segment with a documented retirement benefit program. You must be able to provide one of the following documents: Summary Plan Description as required by the Department of Labor; Employee Welfare Benefit Plan document; Retiree Group Health Care Plan document; Section 125 Cafeteria Plan document; or union contract. The documentation submitted must clearly define retiree eligibility requirements (i.e. age/years of service), employer contributions, surviving spouse options and benefits. A letter from the group will not be accepted in lieu of one of these documents.

NOTE: A retiree program may be established provided there is a corresponding active segment with a minimum of five active, nonretiree, non-COBRA medical contracts (employees) enrolled with BCBSM. An employer-employee relationship must be substantiated for the active segment.

The following requirements apply to retiree enrollment:

- The employer must contribute a minimum of 50 percent of the retiree's and, if applicable, the surviving spouse's health care premium for nonreform groups. Reform groups are not subject to the 50 percent minimum employer contribution requirement.
- The retiree segment level of benefits must not exceed the highest benefit plan offered to the corresponding active segment, unless mandated by a union agreement.
- Only those retired workers who are eligible under the group's welfare benefit plan in which health care benefits are made available are eligible to enroll in the retiree health care program. They must also be fully vested and covered previously in the active segment.

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- All eligible employees who have retired prior to the effective date of the retiree segment are eligible for enrollment at the initial enrollment of the segment provided they are qualified retirees who meet all eligibility requirements.
- Enrolled retirees must be transferred from the active segment to the retiree segment at the time they become eligible for retiree benefits.
- Retired employees who were previously covered in the active segment but are not entitled to benefits until some future date are eligible for enrollment in the retiree segment at the time they become entitled to benefits.
- Only those eligible retirees who waive benefits because they are enrolled in group coverage through another source may enroll at a later date when they lose other group coverage. (Note: This source cannot be retiree coverage through another carrier offered by the employer group.)
- An employee who retires on or after the effective date of the BCBSM retiree program will be eligible to participate as a retiree on the date of retirement provided they meet all eligibility requirements.
- Any retiree or surviving spouse who is eligible for Medicare Parts A or Part B, whether enrolled or not, must enroll in BCBSM Medicare Supplemental coverage. BCBSM coverage will be secondary to Medicare. Some exceptions may apply to retirees and surviving spouses with End-Stage Renal Disease.
- Provided a surviving spouse option is permitted by the group's retiree group health care plan, the group must elect a surviving spouse option and provide the required documentation in order to establish surviving spouse benefits.
- In order for a surviving spouse to continue coverage in the retiree health care plan the retiree had to be eligible and enrolled in the program at the time of death. Surviving spouse coverage does not include a person who marries a member with the surviving spouse coverage. Surviving spouses who waive their health care coverage through the retiree program are no longer eligible for surviving spouse coverage.

Exclusions

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. These include:

- **Spouse**
- **Domestic partners** — This category includes coverage for a subscriber's same-gender domestic partner and dependent children of the partner when your organization has purchased 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.

Note: Proof may be established by a driver's license, voter registration, student identification, city or county registration or other specific documentation.

- A signed and notarized Affidavit of Domestic Partnership is submitted to BCBSM with the *Enrollment/Change of Status* form.
 - 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. Coverage will take affect 90 days after the date the application is approved by BCBSM underwriting.
- **Dependent children** — This category includes children of the subscriber or spouse by birth, legal adoption or legal guardianship. Dependent children are eligible for coverage through the end of the year in which they turn age 19.

Dependent children are eligible if they are:

- Under age 19 and unmarried

NOTE: 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).

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- **Dependent children of domestic partners** — This category includes children of the subscriber's domestic partner. Dependents are eligible for coverage under the subscriber's contract through the end of the year in which they turn 19.

All of the following requirements must be met:

- They are related to the domestic partner by birth, legal adoption or legal guardianship.
- They are unmarried.
- They are the domestic partner's dependents as defined under the United States Internal Revenue Code.
- They are claimed as exemptions on the domestic partner's tax return.
- They reside with the subscriber and domestic partner. If the dependent children do not reside with them, the medical care for the dependent children must be the domestic partner's legal responsibility (copy of court order required).
- The dependent children are dependent on the domestic partner for more than half of their support.

Dependent children of the domestic partner will not be covered unless the domestic partner is also covered on the subscriber's contract.

Coverage for dependent children of the domestic partner will terminate when the partnership ends.

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 eligibility requirements stipulated under Disabled Children.

- **Principally supported children** — This category includes children who are not the offspring of the employee or spouse, but are related by blood or marriage if:
 - The child is under 19 and unmarried.
 - The child legally resides with the subscriber.
 - The child is not Medicare eligible.
 - The child was claimed as a dependent on the subscriber's most recent federal income tax filing. (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.)
 - The child has been principally supported by the subscriber for a minimum of nine consecutive months before coverage is effective.

- **Disabled dependents** — These dependents are the subscriber’s children who are totally and permanently disabled, either a physical disability or mental retardation. Michigan law requires that disabled dependents continue coverage as regular members (that is, not as Family Continuation or Dependent Continuation rider dependents, explained on Page 2-6) if they meet all of the following requirements:
 - They are totally and permanently disabled prior to age 19.
 - They are incapable of self-sustaining employment.
 - We are notified of the condition before the end of the year in which the dependent turns 19 (or age 25 if your plan includes the DC rider, explained on Page 2-6).
 - The disability is certified by a physician.
 - The dependent is unmarried and dependent on the subscriber for more than half of his or her support.
 - The dependent was reported as a dependent on the subscriber’s most recent federal income tax return.

Exclusions

- A foreign exchange student is ineligible for coverage as a dependent on a subscriber’s contract.

Continuation Coverage for Dependents over Age 19

Your organization may have a rider that allows subscribers to continue coverage for dependents through age 25. These riders include the Family Continuation, or FC, rider **or** the Dependent Continuation, or DC, rider. The Sponsored Dependent, or SD, rider covers eligible dependents through any age. Check Part C of your *Group Enrollment and Coverage Agreement*. If you have these riders, they will be listed.

Family Continuation or Dependent Continuation Coverage Riders

A subscriber’s dependent child may continue to be covered if the child meets all of the following requirements:

- The child is between 19 and 25.
- The child is unmarried.
- The child is a member of the subscriber’s household.
- The subscriber provides more than half of the child’s support.
- The child is related to the subscriber by blood, marriage or legal adoption.
- The child is a full-time student for at least five months of the year or received gross income of less than four times the current personal exemption identified by the IRS.

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Sponsored Dependent Coverage Rider

If your organization has the SD rider, sponsored dependents are eligible for coverage. This coverage usually applies to adult children, parents or other individuals who are financially dependent on the subscriber. Coverage is the same as your organization's regular coverage, except that any Master Medical, dental or vision benefits are excluded. To be eligible for coverage, sponsored dependents must meet all of the following requirements:

- The dependent is over 19.
- The dependent is not eligible for coverage as a Family Continuation or Dependent Continuation rider member.
- The subscriber provides more than half of the dependent's support.
- The dependent is related to the subscriber by blood, marriage or legal adoption.
- The dependent is a member of the subscriber's household.