

Frequently Asked Questions

Dependent coverage through age 26



Eligibility

1. How is an eligible dependent defined?

An eligible dependent is defined as being less than 26 years of age, and considered a child of the covered individual by birth, legal adoption, or legal foster arrangement.

A married dependent's spouse and children are ineligible and cannot enroll for dependent coverage.

2. If my group wants to cover sponsored dependents, can they?

The current legislation does not specify regulations for sponsored dependents, so it is the plan sponsor's decision for policies regarding sponsored dependents.

3. Can we offer coverage to select dependent groups, such as those under union employees versus salaried?

All dependents must be provided the same type of coverage as other group members and cannot be discriminated against in terms of the benefits they may receive.

4. If a dependent child between 19 and 26 is eligible for employer sponsored coverage, can he/she purchase an individual policy?

Yes. Just because a dependent is eligible for coverage does not mean a dependent has to accept the coverage.

5. If a dependent child between 19 and 26 has an individual policy, can he/she receive coverage as a dependent child under his/her parent's group contract?

Yes.

6. If a dependent has an offer of employer-sponsored coverage, is he/she still eligible for coverage under his/her parent's plan?

It depends if the plan is considered a grandfathered plan or not. From now until 2014, grandfathered plans do not have to offer coverage to dependents that can get employer-sponsored coverage from their own employment.

Frequently Asked Questions

Dependent coverage through age 26



For non-grandfathered plans, the plan must extend coverage to all dependents less than 26 years of age, even if they are eligible for employer sponsored coverage. Beginning in 2014 for all grandfathered and non-grandfathered plans, dependents that can get employer-sponsored coverage can still be eligible to join their parent's plan.

7. If a married dependent can get coverage under his/her spouse's employer, is he/she still eligible for coverage under their parent's plan?

Yes. A dependent's marital status is not taken into consideration when determining dependent status.

8. If the parent has one benefit option when the dependent child enrolls under the special enrollment opportunity, can the parent change benefit options at that time?

Yes, as long as it is a benefit package available to similarly situated individuals who enroll when first eligible.

9. Are there Michigan residency requirements for dependents?

BCBSM may establish residency requirements for the subscriber, but not for the dependent. The only limitation that can be put on the dependent is the dependent's relationship to the subscriber. Only some of our plans have residency requirements (such as individual plans), but many group plans do not.

10. Are dependent children only eligible for their parent's coverage, or must they be allowed to enroll in any benefit option that the parent's group offers? What if the child is enrolling under the special enrollment opportunity? Does that make a difference?

The dependent is only eligible for coverage in which other similarly situated individuals are eligible. If the plan allows other dependents to enroll all in any coverage the group offers, then dependent children enrolling during the special enrollment opportunity would have the same rights. If the group only allows for dependents to be eligible for their parent's coverage, then that holds true for the special enrollment period as well.

All the extension of dependent care coverage does is to extend the length of time an adult child can be covered on a contract. It does not create new forms of benefits packages that a dependent can take advantage of.

Frequently Asked Questions

Dependent coverage through age 26



Ineligibility

1. When will a dependent that “ages out” be terminated from the contract?

It depends on the group. Fully-insured groups can remove dependents at the end of the calendar year. Self-insured groups may select the dates for terminating coverage for dependents.

Re-enrollment

1. When will BCBSM / BCN re-enroll those that have been dropped from coverage?

Our current systems do not allow for immediate re-enrollment, so we plan on re-enrolling dependents in the new plan year beginning on or after September 23, 2010. This will be an open enrollment period. This period needs to start no later than the 1st day of the new plan year, and cannot be shorter than 30 days. Coverage begins on the 1st day of the new plan year. More details will be provided at a later date.

2. Which dependents are eligible for re-enrollment?

Dependents up to age 26 (not through age 26) and considered to be the child of the covered individual by birth, legal adoption, or legal foster arrangement will be able to re-enroll.

3. If a dependent was previously dropped due to ineligibility or has employer-sponsored coverage, can he/she re-enroll?

He/she can be re-added if they have not reached the age of 26 and meet the other eligibility requirements. For those that were removed from coverage before March 23, 2010, we have not promised to re-enroll these dependents until the appropriate plan year.

4. What are the fees/charges for re-enrollment?

We are currently revising our fee policies for dependents and will provide additional information at a later date.

Frequently Asked Questions

Dependent coverage through age 26



Enrollment Periods

1. When and how long is the enrollment period?

The enrollment period is 30 days, but it may be held at a different time for each plan.

Rates & Charges

1. When will BCBSM / BCN charge me for the additional dependents?

PPACA prohibits charging dependents different rates according to age, so all dependents under age 26 receive the same rate. We are currently in the process of revising our rating practices and policies to comply with this regulation. More information will be provided in a timely manner.

2. How much will BCBSM/BCN charge for additional dependents?

We are currently in the process of revising our rating policies, so more information on specific fees will be provided at a later time.

FC/DC Riders

1. Will the FC/ DC rider structure stay the same?

We are currently reviewing our FC/DC riders to assess their compliance with the new regulations. Updates will be provided at a later time.

Compliance Regulations & Dates

1. What types of groups (fully-insured, self-funded, CBAs) must offer dependent coverage?

Self-insured groups will need to revise their own plans according to the interpretations of the PPACA regulations by their own legal counsel. Plans associated with collectively bargained agreements (CBAs) will be treated similarly as other grandfathered plans, so these plans also need to provide coverage for dependents up to age 26.

FOR INTERNAL USE ONLY: The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. Interpretations of the reform legislation vary and efforts will be made to present and update accurate information. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice. Analysis is ongoing and additional guidance is also anticipated from the Department of Health and Human Services.

Frequently Asked Questions

Dependent coverage through age 26



2. When do CBAs have to comply and provide dependent coverage? Unlike other plans, do CBAs have special delayed implementation dates?

There is no special implementation rule for CBAs. All CBA plans must comply at the same time as non-CBA plans, regardless of when the CBA expires. All grandfathered CBA plans, insured and self-insured, must implement the reforms without a delayed effective date.

This means that all CBA plans must implement certain changes, such as the extension of dependent coverage to children up to age 26, by the first plan year after September 23, 2010.

3. When must a group comply with this provision?

Groups need to comply for their new plan beginning on or after September 23, 2010. If the plan year is not specified in the official plan document, then the plan year is the 12 months following the reset of the deductible. If this is the case, then it is January 1, 2011. It is a business decision whether we let plans opt out of early compliance.

4. What is the difference between “plan year” and “renewal date?”

It is important not to confuse “plan year” with “renewal date,” because they are not necessarily the same date. A “plan year” is defined as the following:

- (1) the plan year designated in the official plan document of a group health plan,
- (2) the deductible or limit year used under the plan (only if the plan document does not clearly state a plan year or if there is no plan document), or
- (3) the policy year (if the plan does not impose yearly deductibles or limits)

5. How does this affect renewals occurring between October 1, 2010 and January 1, 2011?

We are currently discussing policies that will guide the renewal process before the start of these groups' new plan years.

Frequently Asked Questions

Dependent coverage through age 26



6. If a group has both union and nonunion employees, can the entire group wait to comply with the mandates when the last of the union contracts expires? Does it matter how many union employees there are in the group?

PPACA does not directly state whether a group with union and nonunion employees can wait to comply with the mandates until the last of the union contracts terminates. Based on other laws, however, the consensus is that at least 25% of a group's covered members must be under the union contract for the group to take advantage of the delayed effective date for union plans.

Federal Laws versus State Laws

1. Does this law supersede Michelle's law?

No. If BCBSM were to cover full time students as dependents beyond the age of 26, BCBSM would still need to comply with Michelle's Law.

Vision, Dental, and Hearing Coverage

1. Is it mandatory to provide vision, dental, and hearing coverage to dependents?

You do not have to provide stand-alone vision, dental, or hearing coverage to dependents. If any of these products are combined with medical coverage, then they are affected by this provision.

Hearing would be subject to the mandates—but that really should not be an issue since hearing benefits are purchased via a rider that amends the medical-surgical certificates.

2. How are stand-alone vision and dental plans affected?

Stand-alone vision and dental plans are not affected, so there is no requirement to provide dependent coverage of these benefits.

Frequently Asked Questions

Dependent coverage through age 26



Benefits

1. What are the mandatory and optional benefits that dependents can receive?

Dependents must be offered the same set of coverage as other members of the group.

We are still looking for additional clarifications from HHS on specific product changes that must take effect in the new plan year beginning on or after September 23, 2010. We will provide more information after we receive these clarifications.

2. If a preventive service can be billed with a diagnostic/treatment or a screening diagnosis, can a plan reject when it is performed to either diagnose or treat a member?

PPACA does not address this question, but a reasonable interpretation of the law would seem to allow us to reject a claim for a preventive service when it is performed to diagnose or treat a member (assuming the service is not covered under a benefit plan). Additionally, when such services are used to diagnose or treat a member, we could still apply cost-sharing to these services.

External Public Relations

1. I would like to share this information with an external group. Do you have any publications available for distribution?

We are currently working on publications that provide comprehensive insights into the impacts of PPACA on BCBSM/BCN. These will be released in a timely manner.

For internal groups, you may access informational brochures on your MarketSource site. Please contact Marketing Communications if you have trouble accessing the site or the necessary brochures.

Grandfathered Plans

1. How does this provision affect grandfathered plans?

We are still looking for additional clarifications from HHS about the specific impacts of this provision on grandfathered plans. More information will be provided after these clarifications.

FOR INTERNAL USE ONLY: The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. Interpretations of the reform legislation vary and efforts will be made to present and update accurate information. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice. Analysis is ongoing and additional guidance is also anticipated from the Department of Health and Human Services.