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of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Michigan Preexisting Condition Exclusion Rider Criteria for Waiver

Read this First

Your Blue Cross Blue Shield of Michigan individual coverage requires a 180-day pre-existing exclusion period during which coverage for pre-existing medical conditions is not available. A pre-existing condition is a condition or illness the individual has up to six months before becoming enrolled in a health plan, for which medical advice, diagnosis, care or treatment was recommended or received.

Under Federal and State of Michigan legislation, you may be eligible for waiver of the pre-existing condition waiting period if you meet the definition of an 'eligible individual' under HIPAA (Health Insurance Portability and Accountability Act) guidelines by meeting **ALL** of the following criteria.

- You must have 18 months of continuous coverage without any lapse in coverage greater than 62 days during the 18 months of coverage or lapse greater than 62 days between your most recent coverage and the day you applied for this coverage.
- Your most recent coverage must have been through an **employer-sponsored group health plan**. The State of Michigan defines a group health plan as a group with at least two subscribers. If there were not at least two subscribers enrolled at the time you terminated coverage, it is not considered a group health plan. An association with members individually enrolled is not considered a group health plan. Note the certificate may state 'group health plan', but there must be an employer sponsored plan with at least two contracts enrolled.
- If you were enrolled in a group health plan that was subject to COBRA (or some form of state continuation), you must have purchased and exhausted COBRA (or any state continuation benefits) before you meet the definition of 'eligible individual.' Under COBRA, the length of time for which COBRA coverage can be purchased is between 18 and 36 months, depending on your qualifying event.
- You must not have voluntarily terminated your health insurance. If you were enrolled in a group health plan, and you were still eligible for coverage in the group health plan, but chose not to purchase it or to continue it, you are not eligible for individual coverage with BCBSM. You are not eligible for waiver of your pre-existing condition limitation waiting period.
- You must not have been terminated for fraud.
- You must not have been terminated for nonpayment of your health insurance premium.

If you were eligible to enroll in a group conversion program after loss of coverage in a BCBSM group health plan, you may not be eligible for this waiver.

Based on the criteria above, BCBSM will review you for eligibility for waiver of your pre-existing waiting period. You will need to complete the attached questionnaire and provide all requested documentation.

Please complete and sign the questionnaire. You will not be reviewed for waiver unless the questionnaire is complete and signed and all documentation requested has been submitted. You may keep this page for your information

Send this application to:

Blue Cross Blue Shield of MI
600 E Lafayette Blvd.
Detroit, Mi. 48226
Attn: Mail Code 1124

Fax: 313 983 2286

Customer Service: 1-888-288-2738

Application for Waiver of the Pre-Existing Waiting Period

Subscriber Name: _____

Social Security Number: _____ Contract Number: _____

1. **You must show proof of 18 months of continuous coverage without a gap in coverage greater than 62 days.**

Attach the Certificate(s) of Creditable Coverage (CCC) to show proof of 18 months of continuous coverage. This certificate should have been sent to you from your prior insurance carrier or the administrator of your group health plan. If you did not receive this document, you will need to contact your prior carrier to obtain this important document. **If you cannot provide the certificates to verify at least 18 months of creditable coverage with no gap of greater than 62 days, your request for removal of the pre-existing waiting period will be denied.**

Note: a CCC must be provided for **each** adult member (older than 18 years of age) on your contract requesting waiver of the pre-existing condition waiting period. BCBSM will review for waiver for each adult member who is enrolled on your contract.

2. **Was your most recent coverage through an employer-sponsored group health plan? If you have more than one CCC, please answer for your most recent coverage.**

- a. Please indicate if the coverage listed on your most current CCC was for any of the following:

- Medicaid, MiChild or other state or county health program for individuals
- HCTC (Health Care Tax Credit)
- Student Health Insurance
- Coverage as a self-employed individual with no employees enrolled
- Coverage you purchased directly from an insurer as an individual
- Coverage purchased as an association member
- Short Term Medical Policy

If you checked any of the above, your most recent coverage was not a group health plan. Your pre-existing condition waiting period will not be waived.

- b. If you were enrolled in a group health plan with two or more subscribers please provide the following information.

Name of Group Health Plan _____
Employer providing Group Health Plan _____
Address of Employer _____
Benefits Contact Person at Employer _____
Title of Contact Person _____
Phone Number for Contact Person _____

We may wish to contact your employer or prior insurance carrier. By signing this questionnaire you are authorizing Blue Cross Blue Shield of Michigan to speak to your employer or insurance carrier.

- c. Please indicate the total number of employees (full and part time) working for the employer listed in section b above:
- There is only one employee
 - There are less than 20 employees
 - There are more than 20 employees
- d. Check the reason that best describes why you are no longer enrolled in group health coverage.
- I am no longer eligible for coverage.
Provide reason no longer eligible _____
Provide last day you were eligible _____
 - I completed COBRA
Provide begin date for COBRA _____
Provide end date for COBRA _____
Provide COBRA qualifying event:
____ Changed employer
____ No longer meet definition of dependent
____ Divorce
____ Death of Subscriber
____ Disability
____ Terminated or laid off
 - Employer no longer offers health plan.
 - I could not afford the premium available to me.
 - I voluntarily terminated the coverage available to me.
 - Other, please explain _____

3. If you were enrolled in a group health plan that is subject to COBRA guidelines, you must have purchased and exhausted COBRA. Please answer the following questions.

Did your employer notify you of your rights under COBRA and offer you coverage?

- Yes, my employer notified me of my rights to COBRA. Please check the situation that applies to you.

____ I was not offered COBRA
____ I was offered COBRA, but I chose not to purchase it.
____ I was offered COBRA; I purchased it but I did not complete the COBRA benefits available to me.
Provide the reasons why benefits were not completed.

____ I was offered COBRA; I purchased it and have exhausted all benefits available to me.
- No, my employer did not notify me of COBRA. Check the reason(s) that apply

____ There are less than 20 employees, full and part time
____ My employer is a church or religious organization
____ My employer no longer offers a group health plan
____ Other _____

If you were not offered COBRA, please obtain from your employer or COBRA administrator a letter indicating why you were not eligible. Please attach it to this questionnaire along with all other documentation.

If you were offered COBRA but did not purchase it, you are not eligible for waiver of pre-existing conditions exclusion waiting period.

If you purchased COBRA, but did not exhaust all benefits available to you, you are not eligible for waiver of pre-existing conditions exclusion waiting period.

If you purchased and exhausted the COBRA benefits available to you, please attach the notice you received from your group health plan or the COBRA administrator. You would have received one notice prior to loss of coverage and a second after those benefits were exhausted.

I authorize BCBSM to contact my prior insurance carrier, employer and COBRA administrator to obtain any necessary information in order to process my request for waiver of my pre-existing condition exclusion rider waiting period. I understand that BCBSM may collect personal and protected health information (PHI) about me in order to complete my application for coverage. BCBSM will use and disclose this information only in accordance with their Notice of Privacy Practices which is available on bcbsm.com or by calling 313-225-9000.

I understand all of the above information will be used to determine if the pre-existing exclusion period should be waived. I also understand, should the pre-existing condition period be waived, and it is determined at a later date that the information provided was false or misrepresented, that I may be responsible to reimburse BCBSM for any claims incorrectly paid based upon the false or misleading information.

If someone else has completed any part of this form on my behalf, I have reviewed the information and confirm that it is accurate.

Name (please print): _____

Signature: _____ **Date:** _____