**SECTION V**

**Who is Covered**

*{Drafting Note: Use for catastrophic coverage.}*

**A. Who is Covered Under this** [**Contract; Policy**]**.**

You, the Subscriber to whom this [Contract; Policy] is issued, are covered under this [Contract; Policy]. You must live or reside in Our Service Area to be covered under this [Contract; Policy]. If You are enrolled in Medicare, You are not eligible to purchase this [Contract; Policy]. This [Contract; Policy] provides Catastrophic Coverage only. In order to be eligible for Catastrophic Coverage You must also be:

* Under the age of 30 at the beginning of the Plan Year; or
* Exempt from the individual mandate because You cannot afford minimum essential coverage or are eligible for a hardship exception.

If You selected one (1) of the following types of coverage, members of Your family may also be covered if the family member is:

* Under the age of 30 at the beginning of the Plan Year; or
* Exempt from the individual mandate because You cannot afford minimum essential coverage or are eligible for a hardship exception.

**B. Types of Coverage.**

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You, Your Spouse and Your Child or Children, as described below, are covered.

**C. Children Covered Under this** [**Contract; Policy**]**.**

If You selected parent and child/children or family coverage, Children covered under this [Contract; Policy] include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child’s adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. [Coverage also includes Children for whom You are a [permanent] legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.] [[Foster children] [and] [[G;g]randchildren] are not covered.] [[Grandchildren who are chiefly dependent upon You for support [and who live with You]] [and] [[F;f]oster children] are covered.]

*{Drafting Note: Plans may extend coverage to foster children, grandchildren and children for whom the subscriber is a legal guardian. If coverage is extended to grandchildren, the language “and who live with you” is optional.}*

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability (as defined in the New York Mental Hygiene Law), or physical disability and who became so incapable prior to attainment of the age at which the Child’s coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child’s incapacity. We have the right to check whether a Child qualifies and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this [Contract; Policy] at any time.

*{Drafting Note: Use the special enrollment period language below for coverage offered both inside and outside the NYSOH. Use “us” for coverage offered outside the NYSOH and delete the word “qualified”. Use “the NYSOH” and include the bracketed word “qualified” language for coverage offered inside the NYSOH.}*

**D. Special Enrollment Periods.**

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days prior to or after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child involuntarily loses minimum essential coverage, including COBRA or state continuation coverage; including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;
2. You, Your Spouse or Child are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage;
3. You, Your Spouse or Child loses eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary and specialty care; or
4. You, Your Spouse or Child become eligible for new [qualified] health plans because of a permanent move and You, Your Spouse or Child had minimum essential coverage for one (1) or more days during the 60 days before the move; or
5. You, Your Spouse or Child are no longer incarcerated.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child’s enrollment or non-enrollment in another [qualified] health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by [the NYSOH; Us];
2. You, Your Spouse or Child adequately demonstrate to [the NYSOH; Us] that another [qualified] health plan in which You were enrolled substantially violated a material provision of its contract;
3. You gain a Dependent or become a Dependent through birth, adoption or placement for adoption or foster care, or through a child support order or other court order[, however, [foster Children] [and] [Children for whom You are a legal guardian] are not covered under this [Contract; Policy]]; *{Drafting note: Insert language as applicable.}*
4. You gain a Dependent or become a Dependent through marriage and You or Your Spouse had minimum essential coverage for one (1) or more days during the 60 days before the marriage;
5. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents;
6. If You are an Indian, as defined in 25 U.S.C. 450b(d), You and Your Dependents may enroll in a [qualified] health plan or change from one (1) [qualified] health plan to another one (1) time per month;
7. You, Your Spouse or Child demonstrate to [the NYSOH; Us] that You meet other exceptional circumstances as the NYSOH may provide;
8. You, Your Spouse or Child were not previously a citizen, national, or lawfully present individual and You gain such status;
9. You, Your Spouse or Child are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for Cost-Sharing Reductions;
10. You are a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You and Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment;
11. You, Your Spouse or Child apply for coverage during the annual open enrollment period or due to a qualifying event, are assessed by the NYSOH as potentially eligible for Medicaid or Child Health Plus, but are determined ineligible for Medicaid or Child Health Plus after open enrollment has ended or more than 60 days after the qualifying event; or
12. You, Your Spouse or Child adequately demonstrate to the NYSOH that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified health plan through the NYSOH.

[We; The NYSOH] must receive notice and We must receive any Premium payment within 60 days of one (1) of these events.

If You, Your Spouse or Child are applying due to a permanent move or marriage, You, Your Spouse or Child can meet the requirement to demonstrate coverage in the 60 days prior to the permanent move or marriage by having minimum essential coverage for one (1) or more days during the 60 days before the move or marriage; living in a foreign country or in a United States territory for one (1) or more days during the 60 days before the move or marriage; or You are an Indian as defined in 25 U.S.C. 450b(d); or You lived for one (1) or more days during the 60 days before the move or marriage in a service area where no qualified health plan was available through the NYSOH.

**E. Plan Selection Limitations for Certain Special Enrollment Periods.**

**1. Cost-Sharing Reductions and Silver Level Plans.** If You, Your Spouse or Child become newly eligible for Cost-Sharing Reductions and are not enrolled in a silver level [qualified] health plan, You, Your Spouse or Child can only change to a silver level [qualified] health plan.

**2. Gain a Dependent.** If You gain a Dependent, You must add the Dependent to Your current [qualified] health plan, or, if the current [qualified] health plan’s rules do not allow the Dependent to enroll, You and Your Dependents may change to another [qualified] health plan within the same level of coverage (or to one (1) metal level higher or lower if no [qualified] health plan is available at Your current metal level). Your Dependent may also enroll in any separate [qualified] health plan.

3**. Metal Level Plan Selection Limitations for Special Enrollment Periods.** In addition to the plan selection limitations described above, if You qualify for a special enrollment period, You may only make enrollment changes in the same [qualified] health plan or change to another [qualified] health plan within the same metal level of coverage (or to one (1) metal level higher or lower if no [qualified] health plan is available at Your current metal level) for any special enrollment triggering event listed above except the following:

1. You, Your Spouse or Child’s enrollment or non-enrollment in another [qualified] health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by [the NYSOH; Us];
2. You are an Indian, as defined in 25 U.S.C. 450b(d);
3. You, Your Spouse or Child demonstrate to [the NYSOH; Us] that You meet other exceptional circumstances as the NYSOH may provide;
4. You are a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You and Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment; or
5. You, Your Spouse or Child adequately demonstrate to the NYSOH that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified health plan through the NYSOH.

Additionally, if Your Dependent qualifies for any of these same special enrollment periods, You must add the Dependent to Your current [qualified] health plan, or, if the current [qualified] health plan’s rules do not allow the Dependent to enroll, You and Your Dependents may change to another [qualified] health plan within the same level of coverage (or to one (1) metal level higher or lower if no [qualified] health plan is available at Your current metal level). Your Dependent may also enroll in any separate [qualified] health plan.

*{Drafting Note: Use the language below for coverage offered both inside and outside the NYSOH. Use “we” for coverage offered outside the NYSOH and delete the bracketed “we must receive” language. Use “The NYSOH” and include the bracketed “we must receive” language for coverage offered inside the NYSOH.}*

**F. Effective Dates of Coverage for Special Enrollment Periods.**

If You, Your Spouse or Child enroll because You are losing minimum essential coverage within the next 60 days, You are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, or You gain access to new [qualified] health plans because You are moving, and Your selection is made on or before the triggering event, then Your coverage will begin on the first day of the month following Your loss of coverage.

If You, Your Spouse or Child enroll because You got married, Your coverage will begin on the first day of the month following Your selection of coverage. If You, Your Spouse or Child enroll because You gain a Dependent through adoption or placement for adoption, Your coverage will begin on the date of the adoption or placement for adoption. If You, Your Spouse or Child enroll because of a court order, Your coverage will begin on the date the court order is effective.

If You have a newborn or adopted newborn Child and [We; the NYSOH] receive[s] notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which [We; the NYSOH] receive[s] notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 60 days of the infant’s birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn’s initial Hospital stay if one of the infant’s natural parents has coverage for the newborn’s initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify [Us; the NYSOH] of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which [We; the NYSOH] receive[s] notice, provided that You pay any additional Premium when due.

If You, Your Spouse or Child enroll because of the death of You or Your Dependents, Your coverage will begin on the first day of the month following Your selection.

*{Drafting Note: Use the sentence below for coverage offered inside the NYSOH only.}*

[Advance payments of any Premium Tax Credit and Cost-Sharing Reductions are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.]

In all other cases, the effective date of Your coverage will depend on when [We; the NYSOH] receive[s] Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then.

*{Drafting Note: Use “NYSOH” for coverage offered inside the NYSOH. Use “we” for coverage offered outside the NYSOH.}*

**G. Special Enrollment Period for Pregnant Women**

If You are pregnant as certified by a Health Care Professional, You may enroll in coverage at any time during Your pregnancy. [You must provide Us with the certification from Your Health Care Professional that You are pregnant.] Coverage will be effective on the first day of the month in which You received the certification from Your Health Care Professional that You are pregnant unless You elect for coverage to be effective on the first day of the month following certification. You must pay all Premiums due from the first day of the month in which You received the certification that You are pregnant for Your coverage to begin. However, if You elect for coverage to be effective on the first day of the month following certification, You must pay all Premiums due from the first day of the month in which Your coverage is effective.

*{Drafting Note: The bracketed sentence is optional.}*

*{Drafting Note: Use the sentence below for coverage offered inside the NYSOH only.}*

[If You are eligible, advance payments of any Premium Tax Credit and Cost-Sharing Reductions will apply on the first day of the month following Your enrollment with NYSOH.]

**H. Domestic Partner Coverage.**

This [Contract; Policy] covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this [Contract; Policy] also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by:.
	1. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
* The partners are both 18 years of age or older and are mentally competent to consent to contract;
* The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
* The partners have been living together on a continuous basis prior to the date of the application; and
* Neither individual has been registered as a member of another domestic partnership within the last six (6) months;
	1. Proof of cohabitation (e.g., a driver’s license, tax return or other sufficient proof); and
	2. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
* A joint bank account;
* A joint credit card or charge card;
* Joint obligation on a loan;
* Status as an authorized signatory on the partner’s bank account, credit card or charge card;
* Joint ownership of holdings or investments;
* Joint ownership of residence;
* Joint ownership of real estate other than residence;
* Listing of both partners as tenants on the lease of the shared residence;
* Shared rental payments of residence (need not be shared 50/50);
* Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
* A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
* Shared household budget for purposes of receiving government benefits;
* Status of one (1) as representative payee for the other’s government benefits;
* Joint ownership of major items of personal property (e.g., appliances, furniture);
* Joint ownership of a motor vehicle;
* Joint responsibility for child care (e.g., school documents, guardianship);
* Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
* Execution of wills naming each other as executor and/or beneficiary;
* Designation as beneficiary under the other’s life insurance policy;
* Designation as beneficiary under the other’s retirement benefits account;
* Mutual grant of durable power of attorney;
* Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
* Affidavit by creditor or other individual able to testify to partners’ financial interdependence; or
* Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.