Blue Cross Blue Shield Blue Care Network of Michigan

Application for Coverage

Individuals and Families
(Off Marketplace Only)

This application may be used for 2023 individual and family coverage through either Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network of Michigan (BCN), depending on which medical plan you choose. Dental plans, dental with vision, and adult vision plans are only offered through BCBSM, but can be paired with BCBSM or BCN medical plans.

Print in black or blue ink. **Complete all fields unless otherwise noted.** Review your application for accuracy, then sign and date. Your information will be used and disclosed only as permitted by our Notice of Privacy Practices. You can find a copy of our Notice of Privacy Practices on our website at **bcbsm.com/index/common/important-information/privacy-practices.html#Privacy**.

If you'd like to apply for a subsidy or tax credit, are age 30 or older and would like to check your eligibility for a hardship exemption to enroll in a Value Plan or are Native American and eligible for additional cost-sharing benefits, contact a health plan advisor at 1-888-899-3012 or your Blue Cross or BCN Agent.

To get individual medical, dental, dental with vision, or adult vision coverage, you must be a Michigan resident when your coverage starts and intend to reside in Michigan. If you're enrolled in Medicare, you're not eligible for individual medical coverage.

Section I: Coverage and Enrollment

Who will be covered by this plan?

☐ One adult (individual plan) ☐ Multiple people (family plan) ☐ One child only (be sure to complete the "child only coverage" section on Page 3)

Why are you applying?

☐ Annual Open Enrollment November 1, 2022 – January 15, 2023

☐ I have a qualifying event, loss of coverage, or am planning to move to Michigan

☐ Adult only vision coverage (doesn't require a qualifying event)

☐ Dental or Dental with Vision (doesn't require a qualifying event)

Have you had individual or employer-sponsored medical coverage in the past 60 days? ☐ Yes ☐ No

If you had BCBSM or BCN coverage, indicate the 9-digit enrollee ID found on your BCBSM/BCN member ID card. If you don't have your enrollee ID, please enter 000000000: _____.

Note: The availability of continuous coverage depends on your event, event date and application date. Proof of employer coverage is required if you are or were an employer-sponsored member seeking continuous coverage due to loss of employer-sponsored coverage or death of the primary policy holder.

Date of qualifying life event:

_____. Your coverage start date will be assigned after we receive your application.

Internal use only:

Original effective date requested _____ Application ID _____

The below list of qualifying events applies to 2023 plan year coverage. If seeking coverage for the 2022 plan year based on a qualifying life event, contact a health plan advisor at 1-888-899-3012 or your Blue Cross or BCN agent. For a list of supporting proof by event, please visit **bcbsm.com/index/health-insurance-help/faqs/topics/buying-insurance/qualifying-events-special-enrollment/documents.html**. Your event must have taken place within 60 days of your application date to be considered for coverage. Approval of this application and coverage effective date will be determined by BCBSM or BCN, as applicable.

Please select the event that applies to you below.
(Note: to obtain coverage, you must submit supporting proof of the event you select.)

- ☐ Birth, adoption
- ☐ Legal guardianship
- ☐ Gaining or becoming a dependent due to a child support order, foster child placement or other court order
- ☐ Marriage
- ☐ Loss of employer-sponsored group coverage. *Examples: Job loss, employer ended health coverage or terminated contributions toward health coverage or reduced work hours (below the minimum necessary to maintain coverage).*
- ☐ Divorce or legal separation
- ☐ Death of policy holder
- ☐ Dependent aging off or loss of coverage through a parent or legal guardian
- ☐ Involuntary loss from Medicaid or Children's Health Insurance Program (CHIP)
- ☐ Newly ineligible for Advance Premium Tax Credit or Cost Sharing Reduction
- ☐ Loss of student health plan, discontinued or involuntary loss of individual qualified health plan
- ☐ Policy holder became eligible for and enrolled in Medicare
- ☐ Exhaustion of COBRA benefits
- ☐ Moved out of plan coverage area with loss of coverage
  - *Includes moves from outside the country or U.S. territory without loss of coverage*
- ☐ Gained new access to Individual HRA or QSEHRA
- ☐ Gained access to a new plan as a result of a permanent move
- ☐ Events for Dental Only: Loss of Marketplace Dental or Newly eligible for Medicare part B

Other event: _____

Include supporting documentation with your application, or promptly send to:

Email: IBUenrollment@bcbsm.com

Fax: 1-877-486-2172

Individual Membership and Billing
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd., Mail Code 610B
Detroit, MI 48226-2998

Put "QLE Supporting Documents" in the subject line of your email. Your supporting documentation must include the primary applicant's first name, last name, date of birth, phone number, and application submission date.

Please tell us about the main person applying for this plan. All of your information will be kept confidential and only used for this application.

Last name	First name	M.I.	Suffix	Social Security or personal tax ID number	Are you a U.S. citizen or legally present in the U.S.? ☐Yes ☐No

Residential address (can't be a P.O. Box)	City	State	ZIP code	County
Billing address (if different than above)	City	State	ZIP code	County

Email	Primary phone number Type: ☐Fax ☐Home ☐Cell ☐Work ☐Other	Alternate phone number Type: ☐Fax ☐Home ☐Cell ☐Work ☐Other

Gender ☐Male ☐Female	Date of birth (if child only coverage, parent or legal guardian must provide signature).	Current resident or intend to reside in Michigan on the effective date of this coverage? ☐Yes ☐No	During the past six months, **have you used tobacco or nicotine in any form** four or more times per week? ☐Yes ☐No

BCBSM/BCN reserves the right to verify tobacco or nicotine use and to adjust your premium accordingly.

Information about your spouse who is applying for this plan

Last name	First name	M.I.	Suffix	Social Security or personal tax ID number	Are you a U.S. citizen or legally present in the U.S.? ☐Yes ☐No

Gender ☐Male ☐Female	Date of birth	Current resident or intend to reside in Michigan on the effective date of this coverage? ☐Yes ☐No	During the past six months, **have you used tobacco or nicotine in any form** four or more times per week? ☐Yes ☐No

BCBSM/BCN reserves the right to verify tobacco or nicotine use and to adjust your premium accordingly.

Information about your dependent children (under age 26 on the policy effective date) who are applying for this plan

Last name	First name	M.I.	Date of birth	Social Security or personal tax ID number (age one and older required, or under age one if available)	Gender	Relationship*
					☐Male ☐Female	
					☐Male ☐Female	
					☐Male ☐Female	
					☐Male ☐Female	
					☐Male ☐Female	

During the past six months, **have any of the listed dependents used tobacco or nicotine in any form?**
☐Yes ☐No If yes, who? _____

*Dependent relationship codes (we reserve the right to audit documentation for all codes except "N")

N – Child (by birth or adoption) P – Principally supported child A – Child adoption in progress S - Stepchild
C – Court ordered coverage L – Legal guardianship D – Disabled child

Child only coverage

Please complete this section if applying for child only coverage. Child only coverage is available for persons under age 21 on the policy effective date. A separate application is necessary for each child.

Child's last name	Child's first name	M.I.	Suffix	Child's Social Security or personal tax ID number (age one and older required, or under age one if available)	Child's date of birth	☐Male ☐Female	U.S. citizen or legally present in the U.S.? ☐Yes ☐No

Child's residential address (Cannot be a P.O. Box)	City	State	ZIP code	County

Legal guardian's name	Legal guardian's primary phone number	Legal guardian's email	Legal guardian's SSN (optional – used to create member online account)

Legal guardian's address	City	State	ZIP code

Section II: Medical Plan Selection

Your network of affiliated doctors and hospitals may be different based on the product you choose. Please visit **bcbsm.com/find-a-doctor**, or consult your coverage documents, or a Blue Cross and BCN agent for specific network details. The BCN HMO medical plans are managed-care plans; your care will be coordinated by a primary care physician that you select upon enrollment.

Pediatric vision benefits are included in all medical plans.

To view the BCBSM prescription drug formulary, visit **bcbsm.com/2023-select-ppo-druglist.**

To view the BCN prescription drug formulary, visit **bcbsm.com/2023-select-hmo-druglist.**

Premiums are charged for the subscriber, spouse and all adult children age 21 and older, and for the three oldest dependent children under age 21. Child only policies are available on all plans below.

Please select your medical plan from the list below. For plan details and availability, visit **bcbsm.com/myblue**.

Metro Detroit HMO (BCN Plans)

Silver

- ☐ Blue Cross® Metro Detroit HMO **Silver Extra**
- ☐ Blue Cross® Metro Detroit HMO **Silver**
- ☐ Blue Cross® Metro Detroit HMO **Silver Saver**
- ☐ Blue Cross® Metro Detroit HMO **Silver Off Marketplace**

Bronze

- ☐ Blue Cross® Metro Detroit HMO **Bronze**
- ☐ Blue Cross® Metro Detroit HMO **Bronze Saver HSA**
- ☐ Blue Cross® Metro Detroit HMO **Bronze Secure**
- ☐ Blue Cross® Metro Detroit HMO **Bronze Extra**

To learn about the Metro Detroit HMO network, and to see if your doctor is in network, visit **bcbsm.com/marketplace/metro-detroit-hmo/**.

Local HMO (BCN Plans)

Silver

- ☐ Blue Cross® Local HMO **Silver Extra**
- ☐ Blue Cross® Local HMO **Silver**
- ☐ Blue Cross® Local HMO **Silver Saver**
- ☐ Blue Cross® Local HMO **Silver Off Marketplace**

Bronze

- ☐ Blue Cross® Local HMO **Bronze**
- ☐ Blue Cross® Local HMO **Bronze Saver HSA**
- ☐ Blue Cross® Local HMO **Bronze Secure**
- ☐ Blue Cross® Local HMO **Bronze Extra**

To learn about the Local HMO network, and to see if your doctor is in network, visit **bcbsm.com/marketplace/local-hmo/**.

Select HMO (BCN Plans)

Silver

- ☐ Blue Cross® Select HMO **Silver Extra**
- ☐ Blue Cross® Select HMO **Silver**
- ☐ Blue Cross® Select HMO **Silver Saver**
- ☐ Blue Cross® Select HMO **Silver Off Marketplace**

Bronze

- ☐ Blue Cross® Select HMO **Bronze**
- ☐ Blue Cross® Select HMO **Bronze Saver HSA**
- ☐ Blue Cross® Select HMO **Bronze Secure**
- ☐ Blue Cross® Select HMO **Bronze Extra**

Catastrophic

- ☐ Blue Cross® Select HMO **Value** (under age 30 before the plan effective date)

To learn about the Select HMO network, and to see if your doctor is in network, visit **bcbsm.com/marketplace/select-hmo/**.

Preferred HMO (BCN Plans)

Gold

- ☐ Blue Cross® Preferred HMO **Gold**
- ☐ Blue Cross® Preferred HMO **Gold Extra**

Silver

- ☐ Blue Cross® Preferred HMO **Silver Extra**
- ☐ Blue Cross® Preferred HMO **Silver**
- ☐ Blue Cross® Preferred HMO **Silver Saver**
- ☐ Blue Cross® Preferred HMO **Silver Off Marketplace**
- ☐ Blue Cross® Preferred HMO **Virtual Primary Care Silver**

Bronze

- ☐ Blue Cross® Preferred HMO **Bronze**
- ☐ Blue Cross® Preferred HMO **Bronze Saver HSA**
- ☐ Blue Cross® Preferred HMO **Bronze Extra**
- ☐ Blue Cross® Preferred HMO **Bronze Secure**
- ☐ Blue Cross® Preferred HMO **Virtual Primary Care Bronze**

Catastrophic

- ☐ Blue Cross® Preferred HMO **Value** (under age 30 before the plan effective date)

To learn about the Preferred HMO network, and to see if your doctor is in network, visit **bcbsm.com/marketplace/preferred-hmo/** and **bcbsm.com/marketplace/preferred-virtual-hmo/**.

Information about Health Savings Accounts (HSA) can be found on the next page.

Premier PPO (BCBSM Plans)

Gold

- ☐ Blue Cross® Premier PPO **Gold**
- ☐ Blue Cross® Premier PPO **Gold Extra**

Silver

- ☐ Blue Cross® Premier PPO **Silver Extra**
- ☐ Blue Cross® Premier PPO **Silver**
- ☐ Blue Cross® Premier PPO **Silver Saver HSA**
- ☐ Blue Cross® Premier PPO **Silver Off Marketplace**

Bronze

- ☐ Blue Cross® Premier PPO **Bronze Extra**
- ☐ Blue Cross® Premier PPO **Bronze HSA**
- ☐ Blue Cross® Premier PPO **Bronze Secure**

Catastrophic

- ☐ Blue Cross® Premier PPO **Value**
  (under age 30 before the plan effective date)

To learn about the Premier PPO network and to see if your doctor is in network, visit **bcbsm.com/marketplace/ppo/**.

HealthEquity® HSA Option

The following plans can be paired with a Health Savings Account (HSA), powered by HealthEquity®:

- Blue Cross® Premier PPO Silver Saver
- Blue Cross® Premier PPO Bronze
- Blue Cross® Preferred HMO Bronze Saver
- Blue Cross® Select HMO Bronze Saver
- Blue Cross® Metro Detroit HMO Bronze Saver
- Blue Cross® Local HMO Bronze Saver

If you already have our HSA but pick a non-HSA plan, you can still use the money in your HSA account, but can't add money to that account once your new plan starts.

There is no charge per month for our HSA. If you'd like to learn more, visit **bcbsm.com/hsa**. Find more details about Health Savings Accounts on Page 10 of this application.

☐ I would like to elect the HealthEquity® HSA option

Section III: Dental, Adult Vision, and Dental with Vision plan selection

The Affordable Care Act requires that individual market medical plans include the 10 categories of Essential Health Benefits (EHBs), one of which is pediatric dental benefits. However, when sold off the Exchange, the medical plan can exclude pediatric dental coverage as long as it is reasonably assured enrollees have such pediatric dental coverage elsewhere.

This medical plan covers all 10 of the required EHBs for adults 19 years of age and older but excludes pediatric dental benefits for enrollees under 19 years of age. Therefore, you must attest to the one of the following:

☐ All applicants are 19 years of age or older;

☐ I have a separate qualified dental plan with another carrier that includes pediatric dental benefit coverage for applicants under 19 years of age

Insurance company: _____ Policy number: _____

☐ I will have purchased a qualifying dental plan with pediatric dental coverage by the date my medical plan coverage starts

By signing below, I acknowledge that the above statement about the ages of all applicants or about having or purchasing a qualified dental plan that includes pediatric dental coverage is true, to the best of my knowledge and belief, and that BCBSM/BCN will rely on my statement. I certify that my attestation covers all members on the contract.

Signature _____ Date _____

To learn more about dental and vision plans, visit **bcbsm.com/dental**.

All dental plans include access to more than 280,000 dental locations. Visit **mibluedentist.com** to find a dental provider.

Dental plans with vision and Blue Cross® Vision for Adults use the VSP Choice network. Visit **vsp.com** to find a vision provider.

Dental Only Plans	Dental with Adult Vision Plans*	Adult Vision Plans*
☐ Blue Dental℠ PPO Plus 80/60/50	☐ Blue Dental℠ PPO Plus 80/60/50 with Vision	☐ Blue Cross® Vision for Adults – Monthly Billing
☐ Blue Dental℠ PPO Extra 100/70/50	☐ Blue Dental℠ PPO Extra 100/70/50 with Vision	
☐ Blue Dental℠ PPO 80/50/50	☐ Blue Dental℠ PPO 80/50/50 with Vision	☐ Blue Cross® Vision for Adults – Annual Billing
☐ Blue Dental℠ EPO 80/50/50	☐ Blue Dental℠ EPO 80/50/50 with Vision	
☐ Blue Dental℠ PPO 100/50/50	☐ Blue Dental℠ PPO 100/50/50 with Vision	
☐ Blue Dental℠ PPO Pediatric 80/50/50		

*Vision benefits are for adult members who are 19 years or older on their plan effective date. Pediatric vision benefits are included in all BCBSM/BCN medical plans.

If you're applying for Blue Dental coverage and your comprehensive dental coverage from another carrier ended within the last 60 days, you may be eligible for a waiver of your Blue Dental waiting period. Please send in documentation that includes the date your previous coverage ended so that we may review it along with your application. Send your evidence of prior comprehensive dental coverage to:

Individual Membership and Billing
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd., Mail Code 610B
Detroit, MI 48226-2998

Fax: 1-866-392-7528

Email: DirectBilledMembership@bcbsm.com

Section IV: Additional Information

If applying for a medical plan, please answer:

Is anyone listed on this application enrolled in Medicare? ☐ Yes ☐ No

If yes, who? _____

To be eligible for Medicare under age 65, you need to have one of the following:

- A disability and be receiving Social Security disability insurance for more than 24 months
- A diagnosis of end stage renal disease (ESRD)
- A diagnosis of amyotrophic lateral sclerosis (ALS) as defined by the Center for Medicare and Medicaid Services (CMS)

For more information, visit our Medicare page at **bcbsm.com/medicare.**

If you're eligible for Medicare, you can't apply for individual medical coverage. Please visit **bcbsm.com/medicare** to learn more**.**

Section V: Optional Information

These questions are completely optional, but your responses will help us develop programs, products and networks that meet our members' needs. Your responses won't impact your health care options or costs.

1. Please pick a primary care physician (PCP) for each family member on your plan**. If you've selected an HMO plan and don't choose a PCP, we'll pick one for you and your family members.**

   If you don't know your physician's National Provider Identification (NPI) or other information, you can use our provider directory at **bcbsm.com/find-a-doctor** to locate the information.

	Physician's First Name	Physician's Last Name	Physician's NPI	Seen in last year?
Applicant				☐ Yes ☐ No
Spouse				☐ Yes ☐ No
Child				☐ Yes ☐ No
Child				☐ Yes ☐ No
Child				☐ Yes ☐ No
Child				☐ Yes ☐ No

2. My yearly household income is:

☐ Less than $30,000 ☐ $45,001 to $70,000 ☐ Greater than $90,001
☐ $30,001 to $45,000 ☐ $70,001 to $90,000

3. Race (check all that apply for all family members)

☐ White ☐ Filipino ☐ Native Hawaiian
☐ Black or African American ☐ Japanese ☐ Guamanian or Chamorro
☐ American Indian or Alaska Native ☐ Korean ☐ Samoan
☐ Asian Indian ☐ Vietnamese ☐ Other Pacific Islander
☐ Chinese ☐ Other Asian ☐ Other

If Hispanic/Latino, ethnicity (check all that applies for all family members):

☐ Mexican ☐ Chicano/a ☐ Cuban
☐ Mexican American ☐ Puerto Rican ☐ Other

4 Preferred language (if other than English):

☐ Arabic ☐ Hindi ☐ Portuguese
☐ Chinese ☐ Italian ☐ Russian
☐ French Creole ☐ Japanese ☐ Spanish
☐ French ☐ Korean ☐ Tagalog
☐ German ☐ Polish ☐ Vietnamese
☐ Gujarati

Section VI: Payment Options

Your security and privacy are important to us. We keep all your personal, medical and financial information confidential and safe using industry-standard certifications and information privacy practices. You can view our privacy statement at **bcbsm.com/privacy**.

Please tell us how you'll be paying your first monthly premium. Once you submit this application, you'll be enrolled in your plan. Don't worry; all of your payment information will be secure. Acceptable payers are the subscriber, spouse or, when applicable, the parent, blood relative, legal guardian, or other person or entity authorized under the law to pay the premium on the subscriber's behalf.

1. Who will pay the premium for this policy?

☐ Self ☐ Legal guardian ☐ Family member

☐ Other (please specify): _____

2. How do you want to pay your initial premium?

☐ Electronic Fund Transfer (EFT); please complete section below

☐ Bill me (coverage is contingent on payment of first premium being received within 31 days of assigned effective date)

For additional payment options, including credit card, visit **bcbsm.com/payments** once you receive your initial bill. Or log in at **bcbsm.com/paybill**.

If you submit your first payment automatically, your payment will be deducted two to three days after your application is approved. All future premium bills will be mailed directly to you.

Note: You'll receive a monthly bill for future premium payments for all plans.

Electronic Fund Transfer (EFT) automatically deducts your premium payment from an account you designate.

Full name (First, Middle, Last)			
Residential address	Email address		
City	State	Zip code	Primary phone number
Name of financial institution	Type of account ☐ Checking ☐ Savings		
Bank account number	ABA/Routing number (9 digits)		

Automatic payment can't be processed without your signature. I authorize Blue Cross Blue Shield of Michigan (BCBSM) or Blue Care Network (BCN) to deduct this one-time payment from the bank account listed above.

Signature _____ Date _____

Section VII: Consent, Terms and Conditions

BLUE CROSS BLUE SHIELD OF MICHIGAN (BCBSM) OR BLUE CARE NETWORK OF MICHIGAN (BCN) PLANS

ELIGIBILITY

I understand that I'm eligible for this coverage if I, my spouse and my dependents listed on this application are residents of Michigan on the effective date of the policy and that I, my spouse and my dependents listed on this application aren't eligible for and enrolled in Medicare. If anyone on this application is eligible for or enrolled in Medicare, they're eligible for a Dental, Dental with Vision, or Adult Vision Only plan. I certify that I, my spouse and my dependents listed on this application are U.S. citizens or legally present in the U.S. I understand that I must notify BCBSM or BCN immediately if my address changes.

If I am applying for coverage outside of the open enrollment period, I certify that I meet one of the qualifying events defined by the Affordable Care Act (ACA), including but not limited to, birth, adoption, change in marital status, loss of job or loss of group coverage. I am applying within the appropriate special enrollment period (SEP) as determined by my life event, and have provided appropriate documentation of my life event. I understand full details on qualifying events and special enrollment periods can be found at **healthcare.gov**. I am applying for health coverage through BCBSM or BCN, based on the specific plans I selected, and understand that I'll be subject to the terms and conditions of this application, and I agree that I'll also be bound by all provisions in the applicable plan certificates and riders. Approval of this application and coverage effective date will be determined by BCBSM or BCN, as applicable. Additional information may be required of me. Coverage is contingent on payment of first premium being received within 31 days of assigned effective date.

BCBSM or BCN, as applicable, have the right to test for tobacco usage to determine applicable rates, and BCBSM or BCN, as applicable, can retroactively adjust premium rates back to the effective date based on results of tobacco (cotinine) testing. Regular tobacco use is defined as four or more times per week excluding religious or ceremonial use. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting **hhs.gov/ocr/office/file**.

This coverage isn't an employer group health plan and isn't intended in any way to be an employer-sponsored health insurance plan. I certify that neither my or my spouse's employer will contribute any part of the premium, nor will I or my spouse be reimbursed for any part of the premium by the employer now, or in the future except through an Individual HRA or QSEHRA. Premium payments will be accepted from myself, my spouse or, when applicable, the parent, blood relative, legal guardian, or other person or entity authorized under the law to pay the premium on the subscriber's behalf.

I may enroll my eligible spouse and eligible dependents. An eligible spouse is the legal husband or wife of the subscriber, as recognized as legal in the jurisdiction where the marriage occurred. An eligible dependent child is related to the subscriber by birth, marriage, legal adoption, legal guardianship, or foster child placement and under age 26 on the coverage effective date. I understand that coverage for my dependent children will end on the last day of the year in which they reach age 26. These dependent children may apply for their own individual coverage. Disabled, unmarried children may remain covered after they turn 26 if certain requirements are met (not available for pediatric dental). A physician's certification of the dependent child's disability must be received 31 days after the end of the year in which they turned 26 for determination of continuing coverage under my plan.

With regard to costs of hospital and medical services delivered by or paid for by BCBSM or BCN, as applicable, I agree to assign my entire right to recovery of those costs against any person or organization as a result of accident or disease including injuries or disease claimed under worker's compensation laws or acts whether by redemption award or voluntary payment or otherwise to BCBSM or BCN, as applicable.

I certify that the requirements of eligibility are met and that all of the information supplied on this application is true, correct, and complete to the best of my knowledge. Detailed information regarding eligibility is available for viewing in the BCBSM or BCN certificate and at **bcbsm.com**. I understand that the information will be used in reviewing my application and administering coverage and that any misrepresentation or false or misleading information may result in termination or rescission of coverage.

TERMINATION OF EXISTING BCBSM OR BCN COVERAGE OR PRIOR APPLICATIONS
In applying for coverage, I am requesting termination of any other Off-Marketplace BCBSM and BCN individual policy or prior application for BCBSM or BCN Off-Marketplace coverage for which I'm a contract holder and lists the same covered members (if any) for which I have requested coverage with this application. I also request that the prior policy termination be effective as of the effective date of this coverage and prior BCBSM or BCN Off-Marketplace applications be terminated immediately. If I want to maintain my existing coverage when the coverage for which I'm applying becomes effective, I will contact BCBSM/BCN directly. On-Marketplace individual policies need to be terminated by contacting the Marketplace.

RENEWABILITY - MEDICARE
Blue Cross Blue Shield of Michigan and Blue Care Network are prohibited from renewing individual market coverage for an enrollee known to be entitled to Medicare Part A or enrolled in Medicare Part B if it would duplicate benefits to which the enrollee is entitled, unless the renewal is effectuated under the same policy or contract of insurance.

TERMINATION OF COVERAGE
I understand that voluntary termination of my policy, including non-payment of premium, does not qualify as a life event to enroll outside of the annual open enrollment period for myself or my dependents on the policy.

I understand BCBSM or BCN may terminate my coverage, if, including but not limited to, we no longer qualify for coverage under the certificate, we can't provide proof of residency in Michigan, or for misuse of coverage.

HEALTH SAVINGS ACCOUNT OFFERED THROUGH HEALTHEQUITY®
Customers enrolled in HSA eligible plans can pair their plan with a health savings account (HSA) offered through HealthEquity. HealthEquity is an independent company partnering with Blue Cross Blue Shield of Michigan and Blue Care Network to provide health care spending account administration services. An independent and FDIC-insured bank holds the health savings account dollars.

HSA accounts will have no charge per month for administrative fees per funded account. Members with Native American cost-sharing subsidies on any plan can't open an HSA. Likewise, Blue Cross plans that aren't high-deductible health plans (HDHP) aren't eligible to open an HSA account, this includes Blue Cross Plans with "extra" benefits, as some benefits are covered before the deductible is met. If you've already established an HSA and begin to receive these cost-sharing subsidies, or if you switch to a non-HDHP with BCBSM, BCN, or another insurer, you will continue to own the funds in your HSA and may continue to spend from your HSA but you will no longer be able to contribute to and manage your HSA through BCBSM's/BCN's member portal at **bcbsm.com**. BCBSM/BCN will notify HealthEquity of your ineligibility and you'll receive information within one month of the date of ineligibility on how to continue managing your health savings account.

Customers who have an HSA with HealthEquity through their current BCBSM or BCN HDHP and apply for another HDHP with either BCBSM or BCN can continue to manage their HSA through the BCBSM/BCN member portal. If you want to discontinue management of your HSA with HealthEquity through the BCBSM/BCN member portal, you must contact BCBSM/BCN customer service directly to decouple management of your HSA from your Blue Cross Blue Shield of Michigan or Blue Care Network plan.

CATASTROPHIC (VALUE) PLANS
Catastrophic plans including Blue Cross® Premier PPO Value, Blue Cross® Preferred HMO Value and and Blue Cross® Select HMO Value are available to individuals under age 30 or those who've received a certification of exemption from the individual mandate due to affordability or hardship from the Health Insurance Marketplace. All members on the plan, including your spouse and dependents, must be under age 30 before the plan effective date, to be eligible to enroll in a value plan. If you meet this eligibility requirement, you can stay in a catastrophic plan for the duration of the calendar year in which you turn age 30.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I understand that information collected about me as provided by this authorization will be used for the purposes noted below as well as to determine my eligibility for health coverage. BCBSM or BCN may collect personal and protected health information (PHI) about me to process my application for coverage. BCBSM or BCN 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 authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on BCBSM's and its subsidiaries' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefit managers, or other health care providers that have provided treatment or services to me or any of my dependents who are also applying for coverage to disclose medical records, prescription history, medications prescribed and other PHI as requested to BCBSM or BCN.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or who have knowledge of my medical information or the medical information of any of my dependents who are also applying for coverage to disclose medical records information, prescription history, medications prescribed and other PHI as requested to BCBSM or BCN. My authorization includes disclosure of information on the diagnosis and treatment of human immunodeficiency virus (HIV) infection and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes.

This PHI is to be disclosed so that BCBSM or BCN may: (1) perform case, care and disease management, (2) validate rating factors allowable under the Patient Protection and Affordable Care Act (PPACA), (3) administer claims and determine or fulfill responsibility for coverage and provision of benefits, and (4) for other legally permissible purposes, including but not limited to, health care operations.

If BCBSM rediscloses this information, the recipient must obtain an additional authorization from me before it may redisclose the information and, if I provide this authorization, information may be redisclosed by the recipient and is no longer protected. I understand and acknowledge that if I'm applying for coverage from BCN that this restriction on redisclosure doesn't apply, but if BCN does redisclose my information, it may no longer be protected.

I understand that my enrollment with BCBSM or BCN is conditioned upon my authorization to release PHI for the purposes stated above and that if I don't provide authorization, I may not be eligible for enrollment. My signature on this form indicates my approval for the release of PHI from BCBSM or BCN and its subsidiaries and from any of the parties listed above to BCBSM or BCN. A copy or other reproduction of this authorization shall be valid as the original. My authorization expires upon the later of (i) rescission or rejection of coverage by BCBSM or BCN; or (ii) I cause my coverage to terminate or it otherwise expires. I understand that I'm entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at **bcbsm.com** or by contacting my Blue Cross or BCN agent. I understand that revocation won't affect actions taken before BCBSM or BCN or any of the parties identified above receive my request.

REFUND POLICY

I understand that requests to terminate coverage will be accepted by me, the card holder, and if I terminate coverage, BCBSM or BCN will refund the unused portion of the monthly premium that was paid, if applicable. BCBSM or BCN will mail me a check within 30 days from the date of my termination. Details about terminating coverage can be found in the certificate or by contacting the number on the back of my BCBSM or BCN card.

I may terminate my coverage by notifying BCBSM or BCN within 10 days of the effective date of my coverage. I will receive a full refund of my premium. If I terminate my coverage after 10 days, I will receive a prorated refund on the unused portion of my premium.

Refunds for Blue Cross® Vision for Adults will only be granted to those members that have elected to pay annually and have no benefit utilization **by anyone on the contract** for the given year for which premium has been paid in advance. These refunds will be processed by request as of the first of the following month.

Section VIII: Sign and Date

Please review your application for completeness and accuracy, and sign and date below.

SUMMARY OF BENEFITS AND COVERAGE
I understand that a Summary of Benefits and Coverage (SBC) related to the coverage for which I'm applying is available on the web at **bcbsm.com/sbc**. I understand the SBC isn't a contract and that it provides only a general overview of coverage information and, if there is any difference or discrepancy between the SBC and my applicable plan document (including certificates and riders), the plan document will control. I consent to delivery of the SBC electronically via the website. I understand a paper copy is also available, free of charge, by calling BCBSM at 1-888-288-2738 or BCN at 1-888-227-2345, as applicable.

Plan, marketing, and promotional materials
I understand that I'll receive plan information, updates, announcements and reminders from Blue Cross Blue Shield of Michigan and Blue Care Network. I consent to delivery of these materials electronically and understand that a paper version of these may also be available to me free of charge. To discontinue these communications, I can unsubscribe at **bcbsm.com** or by calling the Customer Service number on the back of my member ID card.

bcbsm.com/agentcompensation: This URL will allow members to see information related to agent commissions.

To include a non-opioid directive in your medical records, please fill out the form available at **bcbsm.com/opioids/index/**. Once completed, send or email a copy to your primary care physician.

Approval of this application and coverage effective date will be determined by BCBSM or BCN as applicable.

Signature of primary applicant (if child only policy, legal guardian must sign)	Date

Mail your completed application to:

Individual Membership and Billing
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd, Mail Code 610B
Detroit, MI 48226
Or fax to: 877-486-2172

Area below for Blue Cross and BCN agent use only

Agent first name	Agent last name	5-digit agent code

GA name	GA 2-digit code	National producer number

Name of person entering enrollment information online

First name Last name

Date producing agent accepted paper enrollment form from individual	Date _____ (mm/dd/yyyy)
Date general agent or association received paper enrollment from agent	Date _____(mm/dd/yyyy)
Agent signature	Date signed

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ܐܢ ܐܢܬܘܢ، ܐܢ ܚܕ ܦܠܢ ܐܢܫܐ ܕܗܝܪܘܬܘܢ، ܣܢܝܩܝ ܠܗܘܢ ܗܝܪܬܐ، ܐܢܬܘܢ ܐܝܬܠܘܟܘܢ ܗܘܝܐ ܕܡܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܠܐ ܦܠܛܬܐ. ܠܡܡܠܠܬܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܡܚܘܢ ܥܠ ܡܢܝܢܐ ܕܟܪܛܝܣܐ ܕܐܝܟܐ ܥܠ ܣܬܪܐ ܕܟܪܛܝܣܘܟܘܢ ܝܢ 877-469-2583 TTY:711 ܐܢ ܠܐ ܗܘܝܬܘܢ ܠܝܬܘܢ ܗܕܡܐ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は877-469-2583, TTY: 711)までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.