

Underwriting Guidelines

Individual and Family Plans

EmblemHealth 2027 individual and family insurance plans are underwritten by Health Insurance Plan of Greater New York.

EMBLEMHEALTH-INDUW-2027 — Effective Jan. 1, 2027

EmblemHealth®



Highlights

- An individual must reside in New York state and live or work with the EmblemHealth service area.
- Child coverage until age 26.
- Domestic partner coverage available.

Individual and Family Plans Underwriting Guidelines

Eligibility

In order to be eligible for coverage, individuals must be New York state residents and must live or work within the EmblemHealth service area.

The following children are eligible until the end of the year in which they turns 26 years of age:

- Biological children.
- Legally adopted children.
- Stepchildren.
- Children for whom the insured is in the process of adopting.
- Newborn infants, including newly born infants adopted by the policyholder if the policyholder takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to §115-c of the Domestic Relations Law within 60 days of birth and provided that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, effective from the moment of birth.
- Unmarried dependent children, up to any age, if they are incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability, or physical disability, who became incapable prior to reaching the the age at which the child's coverage would have otherwise terminated are eligible.
- Dependents may be covered through age 29 if the make-available rider is purchased at the inception of the coverage. This rider must be offered at initial enrollment.

Individuals who have Medicare coverage are generally not eligible for a plan available through the NY State of Health (NYSOH) insurance marketplace.

Exception:

- A person who is eligible for Medicare but has not enrolled in it, or who was enrolled but dropped Parts A and B because they would have to pay a premium or are not collecting Social Security benefits.
- Rules requiring guaranteed renewability prohibit us from terminating individuals who enroll in a plan and subsequently enroll in Medicare.
- Medicare-eligible individuals who are covered under a comprehensive individual policy and whose coverage is discontinued (i.e., a class discontinuance) are permitted to convert to any other individual policy than being offered by EmblemHealth. Due to federal Medicare anti-duplication rules, Medicare enrollees are ineligible to newly purchase an individual comprehensive policy from another insurer.





Family Verification

EmblemHealth will request a Federal 1040 form and/or a marriage certificate to verify the marriage of two individuals with different last names. In addition, EmblemHealth will require a birth certificate and/or Federal 1040 Form as proof that a dependent is eligible for coverage if the dependent has a last name different from the subscriber.

Domestic Partners

Domestic partner coverage is available with EmblemHealth.

- A domestic partner will be treated as a dependent.
- Eligible dependents of the domestic partner may be added.
- Domestic partners are not recognized by the Internal Revenue Service (IRS) and may not receive tax benefits afforded to spouses (e.g., health savings accounts).
- Domestic partners must submit the Declaration of Cohabitation & Financial Interdependence Form (DCFIF) to EmblemHealth. It must be notarized. In addition, the partners must also provide three documents showing a similar residence and financial interdependence.

The specific list of acceptable documents is shown on the form.

Guaranteed Renewal

An individual contract must be renewed unless terminated because of the following:

- Fraud or misrepresentation of material facts.
- Non payment of premium within the prescribed grace period.
- The subscriber no longer lives or resides in the service area.
- The insurer ceases offering all hospital, surgical, and medical expense coverage in the state's individual insurance market.
- The insurer stops offering the class of contracts to which the subscriber's contract belongs.

Open Enrollment Periods

Individuals must purchase coverage during an open, limited, or special enrollment period.

- For individuals who submit a complete application and pay their premium between the first and the fifteenth of the month, effective date for coverage must begin on the first day of the following month.
- For individuals who submit a complete application after the fifteenth of the month, coverage may become effective on the first of the following month or the month thereafter.

Special Enrollment Periods

Outside of the annual open enrollment period, individuals can enroll for coverage within 60 days prior to or after the occurrence of one of the following events:

- The individual involuntarily loses minimum essential coverage, including COBRA or state continuation coverage, including enrollment in a non-calendar year group health plan or individual health insurance coverage, even if there's an option to renew the coverage.
- The individual is determined newly eligible for advance payments of the Premium Tax Credit because the coverage will no longer be employer-sponsored minimum essential coverage, including as a result of an employer discontinuing or changing available coverage within the next 60 days, provided that the individual is allowed to terminate existing coverage.
- The individual 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.
- The individual becomes eligible for new qualified health plans because of a permanent move and had minimum essential coverage for one or more days during the 60 days before the move.
- The individual is no longer incarcerated.

Outside of the annual open enrollment period, individuals can enroll for coverage within 60 days after the occurrence of one of the following events:

- The individual'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.
- The individual adequately demonstrates to the NYSOH that another qualified health plan substantially violated a material provision of its contract.
- The individual gains a dependent or becomes 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 the individual is a legal guardian are not covered.
- The individual gains a dependent or becomes a dependent through marriage and the individual or spouse had minimum essential coverage for one or more days during the 60 days before the marriage.
- The individual loses a dependent or is no longer considered a dependent through divorce, legal separation, or upon death.
- If the individual is a native American, as defined in 25 U.S.C. 450b(d), the individual may enroll in a qualified health plan or change from one qualified health plan to another, one time per month.
- The individual demonstrates to the NYSOH that other exceptional circumstances are met as the NYSOH may provide.
- The individual was not previously a citizen, national, or lawfully present individual and gained such status.
- The individual is determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for cost-sharing reductions.
- The individual is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment.
- The individual applies 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 (CHPlus), but is determined ineligible for Medicaid or CHPlus after the open enrollment ended or more than 60 days after the qualifying event.
- The individual applies for Medicaid or CHPlus coverage during the annual open enrollment period and are determined ineligible for Medicaid or CHPlus coverage after open enrollment has ended.
- The individual adequately demonstrates to the NYSOH that a material error related to plan benefits, service area, or premium influenced the individuals decision to purchase a qualified health plan through the NYSOH.

Special Enrollment Period for Pregnant People

Individuals who are pregnant as certified by a health care professional may enroll at any time during pregnancy. EmblemHealth will require the certification from the health care professional to substantiate pregnancy.

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