SHARP Health Plan

# Understanding Eligibility and Special Enrollment



## Am I eligible for coverage?

In order to qualify for health insurance with Sharp Health Plan's individual and family plans, you must:

- ☐ **Be a U.S. resident with proof that you live in your plan network's service area**

  ▸ **What is proof of residency?**
  Proof of residency is documentation that verifies your residential address. When applying for health insurance with Sharp Health Plan, we need to verify that you live in our service area. We're San Diego's health insurance, and in order to ensure that we are serving our fellow San Diegans, we must receive your proof of residency documents within 10 business days of submitting your application.

- ☐ **Submit a complete application for coverage during our annual open enrollment period OR experience a valid qualifying event and submit a complete application for coverage during your special enrollment period**

  ▸ **What is a complete application?**
  A complete application is (1) filled out entirely, (2) signed and dated and (3) includes valid proof of residency.

- ☐ **Include valid qualifying event documentation if applying during a special enrollment period**

**Proof of residency is required for all applicants**

Approval for a Sharp Health Plan individual or family plan requires proof that you live in Sharp Health Plan's service area. Proof of residency documents must be received within 10 business days of the receipt of your application.

- Sharp Health Plan requires two documents clearly stating your full name and the address at which you currently reside.
- Proof of residency documents should be the most recent version of the documents available.

Examples of acceptable residency documents: gas, electricity, water or internet billing statement, bank statement, California driver's license, rental agreement, school records, pay stub, tax return, property tax statement.

Sharp Health Plan may accept other types of documents on a case-by-case basis. No handwritten or expired documents will be accepted.

**! Important things to know**

- Providing the required documentation does not guarantee approval for enrollment.
- All documentation submitted is subject to validation and must support the qualified event or eligibility requirements.
- Coverage cannot become effective before your qualifying event date.
- An application for coverage must be received within 60 days after your qualifying event. For some qualifying events, you may be able to apply 60 days prior to the qualifying event date.
- Your effective date depends on the kind of qualifying event you have.
- Qualifying events do not apply to the remainder of a family on a policy from which an individual no longer qualifies as a dependent.

# What are the qualifying events?

## Special enrollment, explained

If you experience a "qualifying event" outside of open enrollment, you will have a special enrollment period to apply for health coverage. You have 60 days from the date of your qualifying event to send a complete application, including required documents, to enroll in a health plan, in most cases.

**The charts below list the different types of qualifying events and the required supporting documents you'll need in each case.**

## How qualifying events work

A qualifying event can apply to you only, or to your entire family.

**Example:** Your family experiences the birth of a child. Either your child or your entire family could apply for health coverage outside of open enrollment because a birth counts as a qualifying event for special enrollment.

The newborn child's effective date would be their date of birth or the first of the following month. If the child's parents want to make a change to their plan, their effective date would be the first of the following month.

| I Gained or Lost a Dependent Through ... | Documentation Needed |
|---|---|
| **Birth** | Hospital documentation or birth certificate showing baby's date of birth |
| **Adoption** | Adoption order OR final decree |
| **Placement for adoption or foster care** | Copy of court order OR certification of placement from the adoption agency |
| **Marriage** | Copy of marriage certificate with seal |
| **Dependent parents or stepparents**<br>Individual must meet the definition of a qualifying relative under Internal Revenue Service (IRS) rules under Section 26, U.S. Code 152(d). | Copy of IRS tax return with parent or stepparent listed as a dependent or an attestation of a qualifying tax dependent under IRS rules. |
| **Registered domestic partners** | Documentation showing marriage certificate was filed in court |
| **Legal guardianship** | Copy of court documentation of legal guardianship |
| **Medical support order** | Copy of qualified medical support order |
| **I Lost Health Care Coverage Through ...** | **Documentation Needed** |
| **Termination of employment** | Letter on business letterhead from your previous employer confirming all of the following information:<br>• Termination reason and termination date<br>• Name of previous health plan and date of coverage termination<br>• Employer contact name, title and contact information |
| **Loss of dependent status** | Letter or statement from prior health plan stating coverage ended due to age |
| **Death of the subscriber** | Copy of obituary or death certificate |
| **Divorce or legal separation** | One of the following documents:<br>• Copy of Dissolution of Marriage with judge or commissioner's signature and documentation demonstrating loss of coverage<br>• Notice of Termination of Domestic Partnership (notarized) and documentation demonstrating loss of coverage<br>• Copy of the agreed order of legal separation and documentation demonstrating loss of coverage |

| I Lost Health Care Coverage Through … | Documentation Needed |
|---|---|
| **Status change or reduction of hours** | Letter on business letterhead from your employer confirming all of the following information:<br>• Date of status change/reduction of hours<br>• Confirmation that employee is no longer eligible for coverage due to the status change<br>• Name of previous health plan and date of coverage termination<br>• Employer contact name, title and contact information |
| **Exhaustion of COBRA/Cal-COBRA** | Copy of COBRA/Cal-COBRA termination letter confirming exhaustion of coverage |
| **Termination of employer contributions** | Letter on business letterhead from your employer stating the date that contributions toward your and/or your dependent's premium ended |
| **Incurring a claim that would meet or exceed a lifetime limit on all benefits** | One of the following documents:<br>• Letter from your health plan indicating the date that you exceeded the lifetime limits on benefits<br>• Explanation of Benefits from your health plan indicating the date that you exceeded the lifetime limits on the benefits |
| **Involuntary loss of other minimum essential coverage**<br>Loss of minimum essential coverage does not include loss of coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission. | Letter from your previous health plan confirming date of coverage loss and reason for loss. Examples of minimum essential coverage:<br>• Employer-sponsored coverage (self-insured plans, COBRA coverage, retiree coverage)<br>• Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Exchange<br>• Government-sponsored coverage (Medicare, Medi-Cal, CHIP, etc.)<br>• Military coverage (TRICARE) |
| **Termination of any non-calendar year group or individual health plan, including a grandfathered or non-grandfathered health plan, even if I, or my dependent, had the option to renew such coverage** | Renewal notice from your health plan that includes the date of renewal |
| **I Experienced a Life Change Through …** | **Documentation Needed** |
| **Permanent move to the service area** | Verification of recent address change, such as utility billing statement, rental agreement or statement within the past 60 days from (1) your previous residence and (2) your current residence<br>For school-aged children: school enrollment record within the past 60 days from (1) your previous residence and (2) your current residence<br>NOTE: If this qualifying event applies to you, you will still need to submit separate proof of your residency in Sharp Health Plan's service area. See the "Proof of residency is required for all applicants" section on page 1 for details. |
| **Release from incarceration** | Documentation from the releasing facility or the applicable state department of justice indicating the date of release and confirming you were incarcerated during the previous open enrollment period |
| **Returning from active duty as a member of the reserve force of the United States military** | Documentation from the applicable government agency indicating the date of your return and confirming you were on active duty during the previous open enrollment period, such as military discharge papers (DD214) |
| **Returning from active duty as a member of the California National Guard** | Documentation from the applicable government agency indicating the date of return and confirming you were on active duty during the previous open enrollment period |
| **My previous health coverage issuer substantially violated a material provision of the health coverage contract** | Written statement from you explaining the circumstances and the provision of the plan contract that you assert your previous health plan violated. The written explanation must be accompanied by a copy of the Evidence of Coverage or plan contract from your previous health plan |
| **I failed to enroll in a health benefit plan during the immediately preceding enrollment period because I was misinformed that I was covered under minimum essential coverage** | • Letter from the Department of Managed Health Care (DMHC) confirming you have demonstrated the required criteria<br>• Notice from other health plan |

| I Experienced a Life Change Through ... | Documentation Needed |
|---|---|
| **Unintentional, inadvertent or erroneous enrollment or non-enrollment in a qualified health plan as a result of the error, misrepresentation, misconduct or inaction of an officer, employee or agent of the Health Insurance Exchange[1] or the Department of Health and Human Services (HHS), a qualified health plan issuer or a non-Exchange entity providing enrollment assistance or conducting enrollment activities** | Letter from the Health Insurance Exchange[1], HHS or the qualified health plan issuer documenting the erroneous enrollment or non-enrollment that includes the name(s) of the individual(s) with the qualifying event and the date of the notification |
| **Change in eligibility for financial assistance with premiums and/or cost shares** | Documentation from the Health Insurance Exchange[1] indicating change in eligibility for financial assistance with the date of the change |
| **New qualification for app-based driver stipend** | Letter on business letterhead stating the date the employee newly qualifies for the app-based driver stipend |
| **New eligibility to purchase an individual health plan through an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement arrangement (QSEHRA)** | Employer notice with the date that coverage under the ICHRA or QSEHRA takes effect |
| **Paid penalty for not having health coverage** | Receipt showing that the prospective enrollee has paid some or all their Shared Responsibility Penalty to the Franchise Tax Board in the past 60 days |
| **I previously received services from a contracting provider under another health benefit plan for a listed service and that provider is no longer participating in the health benefit plan** | Documentation from your previous health plan indicating the date the contracting provider terminated their contract with the plan and medical records confirming you were receiving treatment from the provider prior to the provider's termination for one of the following services:<br>• An acute condition<br>• Serious chronic condition<br>• Pregnancy<br>• Terminal illness<br>• A pending surgery or procedure that was scheduled to occur within 180 days of your provider's termination<br>• A child aged 0-36 months<br>NOTE: Approval is contingent upon clinical review |
| **I am a victim of domestic abuse or spousal abandonment, OR I am a dependent or unmarried victim within a household, enrolled in minimum essential coverage, and I am seeking to enroll in coverage separate from the perpetrator of the abuse or abandonment** | Proof of minimum essential coverage in the 60 days preceding the application date for at least one of the applicants |
| **I applied for Medicaid or Children's Health Insurance Program (CHIP) coverage on the Health Insurance Exchange[1] or through the state Medicaid or CHIP agency, but the determination of my ineligibility was not communicated to me until after the annual open enrollment period or more than 60 days after the qualifying event (if coverage is applied for during a special enrollment period)** | Notification from the state agency proving ineligibility for Medicaid or CHIP coverage with the date of the notification |
| **Gaining or maintaining American Indian status, OR status of a dependent of an American Indian (applies to on-Exchange[1] only)** | Qualifying event must be referred to the Health Insurance Exchange[1] |
| **New U.S. citizenship or new status as a U.S. national or non-citizen lawfully present in the U.S. (applies to on-Exchange[1] only)** | Qualifying event must be referred to the Health Insurance Exchange[1] |
| **An exceptional circumstance validated by the Health Insurance Exchange (applies to on-Exchange[1] only)** | Qualifying event must be referred to the Health Insurance Exchange[1] |

[1] The Health Insurance Exchange is a service available in every state that helps individuals, families and small businesses get affordable health coverage. California's Health Insurance Exchange agency is Covered California™. Also called "Marketplace" and "Exchange."

# What date will my coverage start?

## Your coverage starts on your effective date

Your effective date depends on the kind of qualifying event you have.

**Here's an example:**

Ron lost his minimum essential coverage on March 31. After looking at his options for health insurance, Ron sent his complete special enrollment application to Sharp Health Plan on April 11. In order for Ron's new health coverage to start on May 1, Sharp Health Plan must receive Ron's required documentation and first payment no later than April 30.

**Use the chart below to see which effective date applies to your situation.**

| My Qualifying Event Involves ... | If I Apply ... | My Coverage Will Start on ... |
|---|---|---|
| **Birth, adoption, placement for adoption or foster care** | Any day of the month | Date of birth, adoption, placement for adoption, foster care, 1st day of the month after your qualifying event, OR the 1st day of the second month after the qualifying event if you request a later effective date |
| **Marriage or domestic partnership registration** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **Dependent parents or stepparents** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **Child support order or other court order to cover a dependent** | Any day of the month | Date the court order is effective |
| **Involuntary loss of other minimum essential coverage** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **Change in eligibility for employer coverage** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **Loss of minimum essential coverage due to the death of the subscriber** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **Divorce, legal separation or dissolution of domestic partnership** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **Termination of non-calendar year plan** | Any day of the month | The 1st of the month after we receive your application |
| **ICHRA or QSEHRA** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **Paid penalty for not having health coverage** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **New qualification for app-based driver stipend** | Any day of the month | The 1st of the month after we receive your application or Account Change Form |
| **All other qualifying events** | Between the 1st and the 15th day of the month | The 1st of the following month |
| | Between the 16th and the last day of the month | The 1st of the second following month |

# How do I apply?

## Submit a special enrollment application

**1. Fill out Sharp Health Plan's special enrollment application within 60 days of your qualifying event date.**

- Go to **sharphealthplan.com/get-a-quote** to fill out an application.

**2. Make sure your application is complete. Check that you have all required documents ready to submit, including:**

- Your application filled out entirely, signed and dated
- Acceptable proof of residency documents stating you live in Sharp Health Plan's service area
- At least one form of documentation to support your qualifying event — additional documents may be required
- First month's premium payment

**3. Please submit your complete application and required documents by mail, email, fax, or in person:**

**By mail or in person:**
Sharp Health Plan
Attention: IFP Sales
8520 Tech Way, Suite 200
San Diego, CA 92123

**By email:**
ifpsales@sharp.com

**By fax:**
Attention: IFP Sales
1-858-499-8246

If you or your dependent parent or stepparent is eligible for or enrolled in Medicare, you have the right to be informed of and understand your specific rights and options before enrolling. The Health Insurance Counseling and Advocacy Program (HICAP) provides insurance counseling to senior California residents free of charge.

**Statewide HICAP Program Telephone:** 1-800-434-0222
**Local HICAP Program Telephone:** 1-858-565-8772
**Local HICAP Address:** 5151 Murphy Canyon Road, Suite 110, San Diego, CA 92123



**If you need assistance, we're here to help.**
You can call Customer Care at 1-800-359-2002 .
We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

# Language Assistance Services

**English**
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

**Español (Spanish)**
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

**繁體中文 (Chinese)**
注意 : 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711)。

**Tiếng Việt (Vietnamese)**
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

**Tagalog (Tagalog – Filipino):**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

**한국어 (Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

**Հայերեն (Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

**فارسی (Farsi):**
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید (TTY:711) 1-800-359-2002 با. باشد می فراهم.

**Русский (Russian):**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-359-2002 (телетайп: 711).

**日本語 (Japanese):**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

**ةيبرعلا (Arabic):**
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. تصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

**ਪੰਜਾਬੀ (Punjabi):**
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**ខ្មែរ (Mon Khmer, Cambodian):**
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002(TTY:711)។

**Hmoob (Hmong):**
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

**हिंदी (Hindi):**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।कॉल करें।

**ภาษาไทย (Thai):**
**เรียน: ถ้าคณพดภาษาไทยคณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร** 1-800-359-2002 (TTY:711).