BeWell New Mexico's Health Insurance Marketplace

BeWellnm.com

# Policy Manual

## Plan Year 2027

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# x. Publication Dates and Updates

The New Mexico Health Insurance Exchange (referred to in this policy manual as "BeWell," "NMHIX," the "Exchange," or the "Marketplace") will update this policy manual annually for the upcoming plan year. A draft of the manual will be published for public comment prior to the final publication. BeWell will distribute separate policy briefs if/as policies are revised or added during the plan year.

## 0.1 Litigation Note

Portions of the Marketplace Integrity and Affordability final rule were vacated by a federal district court. Other provisions of the 2027 Notice of Benefit and Payment Parameters were stayed by a federal district court. Although the corresponding text may still appear in the Code of Federal Regulations, those provisions are not currently in effect and are not implemented by BeWell. This policy manual reflects the current legal requirements and will be updated and distributed if further litigation changes these requirements.

# 1 Overview

## 1.1 Purpose

The purpose of this document is to provide important information for stakeholders and individuals about the operational policies of BeWell, and to serve as a tool for the proper handling of individual cases.

## 1.2 Definitions and Acronyms

See Appendix A for definitions of common terms and acronyms.

## 1.3 Resources

The BeWell website includes a variety of useful resources, ranging from information about the Affordable Care Act (ACA) to information about getting assistance with applications. Please visit http://www.bewellnm.com to learn more.

Stakeholders and individuals may also contact BeWell at 1-833-862-3935 (TTY: 711), or by chatting with customer service staff via the website.

# 2 Eligibility

An individual completes a single streamlined application for enrollment in Marketplace health insurance coverage through BeWell. The single streamlined application is used

to determine eligibility to (1) shop for and enroll in medical and/or dental coverage; and (2) apply for financial assistance programs, including advance payments of the premium tax credit (APTC), state financial assistance, and health plans with reduced cost-sharing, including State Out of Pocket Assistance (SOPA) or federal cost-sharing reductions (CSR).

Individuals can also use the application to apply for Medicaid. The New Mexico Health Care Authority (HCA) makes the final Medicaid eligibility determinations for individuals assessed by BeWell as likely to be eligible for Medicaid.

## 2.1 Who Is Eligible

45 CFR 155.305(a)

An individual is eligible to shop for medical or dental coverage, with or without financial assistance, through BeWell by attesting to and verifying, where applicable, the following criteria:

- The individual is a United States citizen, national, or a non-citizen who is lawfully present in the United States;
- The individual is not incarcerated, other than incarcerated pending the disposition of charges; and
- The individual is a resident of the State of New Mexico, if they live in New Mexico or intend to reside in New Mexico by the coverage effective date.

### 2.1.1 Who Is Considered "Lawfully Present"

45 CFR 155.20; 45 CFR 155.300; 45 CFR 155.305

Individuals with the following immigration statuses are considered lawfully present:

- Lawful Permanent Resident (LPR) (without having met the 5-year bar)
- Individual who is seeking, or has been granted, political asylum
- Refugee
- Cuban and Haitian Humanitarian Parolees
- Certain Afghan Evacuees or Ukrainian, Cuban, Haitian, Nicaraguan, or Venezuelan Humanitarian Parolees
- Cuban/Haitian entrant
- Certain Ukrainian nationals
- Paroled into the U.S.
- Granted parole for less than one year, including Nicaraguan and Venezuelan Humanitarian Parolees

- Granted parole for at least one year, including Nicaraguan and Venezuelan Humanitarian Parolees
- Conditional entrant (granted before 1980)
- Battered spouse, child, or parent
- Victim of trafficking and their spouse, children, siblings, or parents
- Granted withholding of deportation or withholding of removal (under immigration laws or under Convention Against Torture (CAT))
- Temporary Protected Status (TPS)
- Lawful Temporary Resident
- Individual with non-immigrant status (includes worker visas, student visas, and citizens of Micronesia, Marshal Islands, and Palau)
- Administrative order staying removal issued by the Department of Homeland Security
- Member of federally recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa
- Deferred Enforced Departure (DED)

**or**

- An applicant for any of these statuses:
- Adjustment to LPR status
- Temporary Protected Status (TPS) with employment authorization
- Special immigrant juvenile status
- Victim of trafficking visa
- Asylum (those who are granted employment authorization, or are under the age of 14 and have had application pended at least 180 days)
- Withholding of deportation or withholding removal (under immigration laws or under CAT)

**or**

- Individuals with the following statuses who have employment authorization:
- Registry applicants
- Order of supervision
- Applicant for cancellation of removal or suspension of deportation
- Applicant for legalization under the Immigration Reform and Control Act (IRCA)
- Legalization under the LIFE Act

Please note that, due to changes enacted in Public Law 119-21 (also known as H.R. 1) in July 2025, eligibility for federal financial assistance for immigrants and other noncitizens will change for Plan Year 2027. See sections 2.2 and 3 for more information about noncitizen eligibility.

For more information about coverage options for non-citizens, visit BeWell's Help

page.

## 2.2 Federal Financial Assistance: Advance Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR)

45 CFR 155.305(f)(1-6); 42 CFR 600.5, 45 CFR 155.20

Individuals who are eligible to shop for health coverage through BeWell may also seek financial assistance to pay for the coverage. Individuals may be eligible for financial assistance by attesting to and verifying, where applicable, that they meet the following criteria:

- Have a projected annual modified adjusted gross income (MAGI) at or over 100% of the Federal Poverty Level (FPL) and up to 400% of the FPL;
- Are a tax filer, or a member of a household with a tax filer, who is married and filing jointly OR is single and filing single;
- Be a citizen of the U.S. or meet the definition of “eligible noncitizen” by qualifying as a lawful permanent resident (LPR) or Green Card holder, a Cuban or Haitian entrant, or a lawful resident of the U.S. under a Compact of Free Association (COFA) with the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), or the Republic of Palau;
- Are not eligible for or enrolled in other qualifying minimum essential coverage (MEC), such as Medicare, Medicaid, other government-sponsored health insurance, or affordable employer-sponsored insurance that meets minimum value requirements;
- Will file taxes for the year in which a tax credit is received. Married individuals must file jointly to receive a tax credit, except for victims of domestic violence or spousal abandonment; and
- Filed a federal income tax return and reconciled the APTC for any required year in which the individual (or the individual’s spouse or dependents) received APTC.

**Note:** A court order issued June 12, 2026, vacated a longstanding federal failure-to-reconcile (FTR) policy in regulation by which consumers could be denied future APTC if they did not file a federal income tax return and reconcile previous years’ APTC. Even though this court action effectively removes the penalty for not reconciling this year, BeWell encourages all consumers to do so each year to catch and correct any APTC overpayments that could become larger tax liabilities over time. In addition, the FTR policy will go back into effect for Plan Year 2028 under federal law.

**Note:** While lawfully present immigrants who do not meet the definition of "eligible alien" will not be eligible for federal financial assistance, the Health Care Authority has increased the amounts of New Mexico Premium Assistance these noncitizens may qualify for in Plan Year 2027. See section 3.6 for more information about state financial assistance, or visit the HCA's page about financial assistance available through the Health Care Affordability Fund.

An individual or family can determine their APTC eligibility by completing the application. Individuals who are determined eligible for APTC must enroll in coverage through BeWell to receive financial assistance.

**Note:** Most adults with incomes below 138% of the FPL will be eligible for Medicaid. Medicaid eligibility categories for children have higher income thresholds, up to 300% of the FPL. Additional information about income thresholds for coverage programs can be found on BeWell's website.

**Note:** Lawfully present individuals who were ineligible for Medicaid due to immigration status are not eligible for APTC if household income is less than 100% of the FPL. See section 3.6 for information about state financial assistance.

# 3 Cost-Sharing Reductions (CSR)

45 CFR 155.305(g)(1)(i)(A)-(C); 45 CFR 155.20; 26 USC 36B(e)(2)(B).

Cost-sharing reductions lower the out-of-pocket expenses (copays, coinsurance, and deductibles) for a qualified individual or family for a qualified health plan (QHP) only. To qualify for a cost-sharing reduction, an individual or family must:

- Be eligible to enroll in a QHP through BeWell;
- Be eligible for APTC;
- Be a citizen of the U.S. or meet the definition of "eligible noncitizen" by qualifying as a lawful permanent resident (LPR) or Green Card holder, a Cuban or Haitian entrant, or a lawful resident of the U.S. under a Compact of Free Association (COFA) with the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), or the Republic of Palau;
- Purchase a Silver plan through BeWell; and
- Have a household MAGI less than or equal to 250% of the FPL.

**Note:** Most individuals and families who are eligible for CSR plan are also eligible for State Out-of-Pocket Assistance (SOPA) plans, which further lower cost sharing. Therefore, when shopping Turquoise Plans will be presented in place of Silver plans, in most cases. See section 3.6.3 for information about SOPA plans (also known as Turquoise Plans) available through the Health Care Affordability Fund.

## 3.1 Cost-Sharing Reductions for American Indians/Alaska Natives

45 CFR 155.350(a); 45 CFR 155.305(g)(1)(ii); 25 USC 450b(d)

Additional cost-sharing reductions are available to an individual who is an American Indian/Alaska Native (AI/AN) as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act. An AI/AN individual can use available CSR on Bronze, Silver, Gold, or Turquoise level plans.

An AI/AN individual enrolled in a Marketplace plan will not be responsible for any cost-sharing requirement for an item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contracted health services.

An AI/AN individual who is eligible for a Marketplace plan with a premium tax credit, and who has a household MAGI between 100% and 300% of the FPL, can choose a zero cost-sharing plan. This means the individual will not have any out-of-pocket costs, such as deductibles, co-pays, or co-insurance, when getting essential health benefits through a Marketplace plan.

An AI/AN individual enrolled in a Marketplace plan with an income below 100% or above 300% of the FPL can choose a plan with limited cost-sharing.

See section 3.6.3 for information about state out-of-pocket plan (also known as Turquoise Plans) available through the Health Care Affordability Fund.

### 3.1.1 Mixed Household Eligibility – AI/AN and Non-AI/AN Members

In cases where a household includes both American Indian/Alaska Native (AI/AN) individuals and non-AI/AN individuals, and the household chooses to enroll together in the same shopping group, the Marketplace will apply the next available eligibility level that can be applied uniformly to all members of the group. As such, the household will not receive the AI/AN benefits.

**AI/AN-Specific Cost-Sharing Provisions**

AI/AN individuals may qualify for:

- Zero cost-sharing plans (if household MAGI is between 100% and 300% of the FPL and eligible for premium tax credits);
- Limited cost-sharing plans (if income is below 100% of the FPL or 300%-400% of the FPL);
- Ability to use CSR benefits on Bronze, Silver, Gold, or Turquoise plans; or
- A limited cost-sharing Turquoise plan (90% AV) (if income is between 300%

and 400% of the FPL).

These provisions apply only to the AI/AN individual, not to non-AI/AN household members. Mixed eligibility households can shop for separate plans to ensure application of the best benefits.

## 3.2 Income Used for Financial Assistance Application

45 CFR 155.320 (c)(ii); 45 CFR 155.320 (E)(ii)(iii)

Financial assistance (e.g., APTC) is based on a household's expected income for the year of coverage being applied for, not the prior year's income. Generally, household income includes the income of the tax filer, their spouse, and their tax dependents (even if the spouse or dependents don't need coverage). Income is used to determine whether an individual or family is eligible to receive APTC/CSR and, if eligible, how much APTC they may receive. It is important to estimate annual household income as accurately as possible since tax credits are calculated using the estimated taxable income.

Taxable income is based on the following common types of income:

- Wages/salaries
- Social Security retirement and Social Security disability
- Unemployment
- Self-employment
- Retirement or pension
- Rent or royalty
- Capital gains
- Interest, dividends, or other investment income
- Alimony (if finalized before January 1, 2019)
- Tips and gratuities
- Farming or fishing income

Non-taxable income is not factored into APTC calculations. This income may include the following:

- Supplemental Security Income (SSI)
- Child support
- Workers' compensation
- Temporary Assistance for Needy Families (TANF)
- Veteran's benefits
- Federal income tax refunds
- Insurance proceeds (accident, health, and life)

The BeWell application will collect information about current income to assist in estimating income for the year of coverage. Individuals can attest to the total

income calculation or make changes to their projected income. For more information about income and eligibility, visit BeWell's Help page.

### 3.2.1 Verification of Income for a Financial Assistance Application

45 CFR 155.320(c); 45 CFR 155.305(f)(1); 26 CFR 1.36 B-1

BeWell uses trusted data sources, like the Internal Revenue Service (IRS) and the Social Security Administration (SSA), to verify the applicant's self-reported income. BeWell considers an applicant's attestation "reasonably compatible" with the data sources if the amount attested to is no more than 50% or $12,000 lower (whichever is greater) than the information provided by the data sources. Reported income that is higher than information from the trusted data source will be accepted and is not subject to the reasonable compatibility threshold. If the data returned is deemed not reasonably compatible, the individual will be asked to provide further documentation to verify income.

## 3.3 Determining Premium Tax Credit Amount

BeWell considers several factors when calculating the premium tax credit, including:

- Age of individual(s) as of the effective date of coverage
- Household's projected modified adjusted gross income (MAGI)
- Household size
- Number of household members requesting and eligible for the premium tax credit
- Premium of the second lowest cost silver plan (SLCSP) available in the county.

Tax households are made up of the tax filer(s) and any individuals who are claimed as dependents on one federal income tax return. Generally, this will include all the individuals that the primary tax filer will claim an exemption for, including the following:

- Self
- Spouse
- Qualified children (as defined by IRS)
- Qualified dependents (as defined by IRS)

In cases of divorce, the parent who claims the child as a dependent on their tax return is the only parent who can claim the child for purposes of APTC calculation.

### 3.3.1 Calculating Age of Household Members

45 CFR 147.102

BeWell will calculate APTC using the ages of the household members as of the effective date of coverage.

### 3.3.2 Household Composition

26 CFR 1.152-2

To align with federal tax households, BeWell will consider the following household relationships when calculating APTC:

- Spouse
- Child
- Adopted child
- Stepson/stepdaughter
- Ward
- Anyone who is in the tax filer's legal custody (e.g., grandchild)
- Qualifying relatives recognized by the IRS

**Note:** Generally, for purposes of calculating APTC, households are made up of tax filers and their tax dependents. Everyone in a tax household must be included in the APTC calculation.

## 3.4 Employer-Sponsored Coverage Affordability

26 CFR 1.36 (b-2)(C)(3); 26 CFR 1.36 (b-1), (e)(2); 26 CFR 1.36(b)(3); 26 CFR 601.105; 45 CRF 155.320(b)

Individuals with access to employer-sponsored coverage must provide information regarding the offered coverage on their application. To qualify as MEC, employer-sponsored coverage must be affordable and must meet minimum value standards for self-only and family coverage.

The cost of the annual premium for the lowest-priced self-only plan must be less than 10.22% of annual household income in 2027 to be considered affordable. If the self-only coverage is affordable, the individual will not be eligible for financial assistance if they enroll in coverage through BeWell.

The cost of the annual premium for the lowest-priced family coverage plan must be less than 10.22% of annual household income in 2027 to be considered affordable. If the family coverage is affordable, the family will not be eligible for financial assistance if they enroll in coverage through BeWell.

If the cost of the employee's self-only or family coverage is considered

unaffordable, the individual and/or family may enroll in coverage through BeWell and receive financial assistance if otherwise eligible. More information on the elimination of the "family glitch" can be found on BeWell's Help page.

## 3.5 APTC Eligibility

### 3.5.1 Applying for APTC When Eligible for Retirement Coverage

26 CFR 1.36 B-2(c)(3)(v); 45 CFR 156.145

An individual who is enrolled in retirement health insurance coverage can only purchase Marketplace coverage and apply for financial assistance if their current retirement coverage does not qualify as MEC. An individual may be eligible for APTC if the retirement coverage is not affordable, and the individual is not currently enrolled.

**Note:** An individual whose retirement coverage ends outside of the annual Open Enrollment Period (OEP) and who chooses not to re-enroll is eligible for a Special Enrollment Period (SEP).

### 3.5.2 Applying for APTC When Enrolled in COBRA

26 CFR 1.36B-2(c)(3)(iv)

Individuals who are offered Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage can apply for coverage with APTC through BeWell instead of enrolling in COBRA.

An individual who is enrolled in COBRA coverage may be eligible for coverage through BeWell but will not be eligible for financial assistance until their COBRA coverage expires, the employer stops contributing to COBRA, or they voluntarily drop their COBRA coverage and enroll in a new policy through BeWell during the annual OEP. Individuals cannot voluntarily drop their COBRA coverage to enroll in coverage through BeWell outside of the OEP.

**Note:** An individual who is enrolled in COBRA coverage and ends the COBRA coverage early due to non-payment will not qualify for an SEP outside of the OEP.

### 3.5.3 Medicare and APTC/CSR

26 CFR 1.36B-2(c)(2)

Individuals who are eligible for or receive Medicare are not eligible to receive APTC/CSR, in most cases.

Individuals who receive Medicare Part A at a cost may drop Part A and Part B

coverage, or they can choose not to enroll in Medicare at the time they become eligible. (These individuals may be subject to tax penalties or Medicare penalties if they defer Medicare enrollment outside of the qualifying time.)

- Individuals who receive free Medicare Part A cannot drop it without also dropping their retiree benefits (i.e., Social Security) and paying back all retirement benefits received and costs incurred by the Medicare program.

- Individuals over 65 years old who elect not to receive retirement benefits, or who are not eligible for Medicare, may be eligible for financial assistance if they purchase Marketplace coverage through BeWell.

Individuals who become eligible for benefits under Medicare while enrolled in coverage through BeWell may maintain their Marketplace coverage, but their financial assistance will be terminated. BeWell will send a notice explaining the change, and the individual will have 30 days to respond before BeWell acts if they believe the information is incorrect. Carriers will be informed of changes to an individual's coverage via the 834 transaction process, whereby member enrollment data is shared. Individuals newly enrolled in Part A only or Part A and B may purchase full-price coverage through BeWell.

**Note:** Medicare Part B alone is not considered MEC. However, if someone is eligible for Part B, it is assumed they are also eligible for Part A, and they won't be eligible for APTC.

**Note:** Individuals who are eligible for or enrolled in Medicare may purchase a stand-alone dental plan through BeWell.

### 3.5.4 APTC and CSR Effective Dates

45 CFR 155.310; 45 CFR 155.340; 45 CFR 155.330(b)(1)

Individuals who are enrolled through BeWell in a plan with financial assistance and experience a change that impacts their eligibility, such as projected annual income or household size, are required to report the change to BeWell within 30 days.

If changes are reported by the last day of the month, the new APTC amount will be effective on the first day of the following month.

Individuals who are enrolled in coverage through BeWell with no financial assistance and subsequently gain eligibility for APTC will have the new APTC amount applied to their premiums as described in this policy manual. Individuals who are enrolled in coverage through BeWell and have a change in APTC or CSR will have their new APTC amount and/or CSR level applied to their enrollment as described in this policy manual.

### 3.5.5 Applying APTC to Qualified Dental Plans

Individuals or families enrolled in a QHP through BeWell may only apply tax credits to a Qualified Dental Plan (QDP, or stand-alone dental plan) if they have applied the maximum amount of tax credit to their QHP and there are credit funds remaining. Tax credits may only be used to defray the portion of a QDP premium allocable to the pediatric dental essential health benefit and would only be applied if a minor (under age 19) in the household was not receiving the pediatric dental benefit through the family's medical plan.

Any tax credits will be effective on the first day of the first full month during which the individual is enrolled in a QHP and QDP and not enrolled in other MEC.

### 3.5.6 APTC and Tax Reporting

Individuals who are enrolled in a health plan through BeWell and use APTC to lower their monthly premium payment are required to "reconcile" the APTC received during the plan year with the premium tax credit (PTC) allowed when filing their federal tax returns.

The tax reconciliation process may result in a tax refund if the individual has received less APTC throughout the plan year than eligibility allows; it may result in tax owed if the individual has received more APTC than they were eligible for. There are no caps on excess APTC amounts the federal government can require to be repaid.

### 3.5.7 State Subsidies and Tax Reporting

Enrollees are not required to reconcile NMPA and NAPA payments on their coverage year tax returns as they do for APTC. NMPA and NAPA cannot be applied to dental plans.

## 3.6 Health Care Affordability Fund (HCAF)

BeWell and the New Mexico Health Care Authority administer programs established in New Mexico law with funding from the New Mexico Health Care Affordability Fund (HCAF). These programs are collectively referred to as the Marketplace Affordability Program (MAP). The Marketplace Affordability Program includes the programs outlined below. This policy manual contains only a summary of the Marketplace Affordability Program. More detailed information can be found on the Health Care Authority website: Health Care Affordability Fund.

### 3.6.1 New Mexico Premium Assistance (NMPA)

NMPA lowers monthly premium costs for eligible New Mexicans.

NMPA provides:

- For individuals and families with income of up to 200% of the FPL: no-cost premium options
- For individuals and families with income above 200% of the FPL: reduced premium options, capping the cost of the SLCSP at 8.5% of the household income on a sliding scale

The Puente Health program provides:

- For individuals and families who are lawfully present noncitizens who were determined ineligible for Medicaid or APTC under HR 1 provisions and with income at or below 400% of the FPL: no-cost or reduced premium options

The Middle Income Households program provides:

- For individuals and families with income above 400% of the FPL: reduced-premium options, capping the cost of the SLCSP at 8.5% of the household income

### 3.6.2 Native American Premium Assistance (NAPA)

American Indian and Alaska Native (AI/AN) individuals and families with household incomes up to 300% of the FPL who qualify for federal premium tax credits through BeWell are eligible for NAPA. NAPA provides no-cost premium options.

For AI/AN individuals with household incomes between 300% and 400% NMPA is available to provide reduced premium options.

### 3.6.3 State Out-of-Pocket Assistance (SOPA) – Turquoise Plans

Individuals and families with household incomes up to 400% of the FPL who qualify for federal premium tax credits through BeWell are eligible for SOPA, also known as Turquoise Plans. Turquoise Plans provide extra savings on out-of-pocket costs for certain plans.

There are three levels of Turquoise Plans in Plan Year 2027, based on household income:

- Up to 150% of the FPL (Turquoise 1)
- Over 150% through 200% of the FPL (Turquoise 2)
- Over 200% through 400% of the FPL (Turquoise 3)*

### 3.6.4 Medicaid Transition Premium Relief (MTPR)

The Medicaid Transition Premium Relief program covers one month of premium

for individuals or families who lose Medicaid coverage and enroll in Marketplace coverage through BeWell. This program is available to individuals and families who:

- No longer qualify for Medicaid; and
- Have an income at or below 400% of the FPL.

The maximum amount of available APTC and NMPA will be applied to the premium before the MTPR is applied.

**Note:** Beginning in Plan Year 2027, Medicaid beneficiaries who lose their Medicaid coverage due to failure to meet the community engagement requirements will be treated as having lost their coverage for procedural reasons. This means they will be ineligible for federal and state financial assistance.

### 3.6.5 Clear Cost Plans

New Mexico offers standardized health plans at the Silver, Gold, and Turquoise levels. Standardized health plans, also known as “Clear Cost Plans”, have the same out-of-pocket costs in the health plan category for covered benefits. By offering standardized out-of-pocket costs, the shopping experience is simplified and streamlined, giving consumers a way to compare offerings from each health insurance carrier, feature-to-feature, without having to compare each benefit individually.

# 4 Medicaid Eligibility and Financial Assistance Applications

BeWell will assess applications for health coverage with financial assistance for Medicaid eligibility. If one or more members of a household are assessed as likely eligible for Medicaid, their application(s) will be transferred to HCA for a final determination of Medicaid eligibility.

**Note:** Medicaid with limited benefits, such as Family Planning, is not considered MEC. Applicants found eligible for and/or enrolled in Family Planning Medicaid are still eligible for financial assistance, such as tax credits, through BeWell.

## 4.1 Requesting a Final Medicaid Determination

Applications of individuals assessed as likely ineligible for Medicaid will not be sent to HCA for a final determination of Medicaid eligibility. However, an individual may elect to have their application sent to HCA for a final Medicaid determination.

# 5 Catastrophic Plans and Exemptions

45 CFR 155.605

Catastrophic Plans will not be offered on the Marketplace for Plan Year 2027.

# 6 Application for Health Coverage

## 6.1 How to Apply

An individual may apply online, by phone, or by mail using BeWell's designated application. The online application can be accessed here: Apply. A paper application can be downloaded here: Enrollment and Consumer Forms. Certified assisters are available to help individuals with their applications at no cost. Individuals can find free local help from upcoming events, assisters, and more at the BeWell website, or by calling BeWell at 1-833-862-3935 (TTY: 711).

### 6.1.1 Verification of Application Information

When an individual applies for health coverage through BeWell, they agree (or "attest") to the truth of the information provided by signing the application. BeWell will use the applicant's attestations, in combination with trusted data sources, like the Internal Revenue Service (IRS) and the Social Security Administration (SSA), to determine eligibility to purchase coverage, and if applicable, eligibility for financial assistance. If an individual attests to meeting the eligibility criteria and such attestation cannot be verified by trusted data sources, BeWell may send a notice to request additional documentation from the applicant. This notice is called a Request for Information (RFI). The RFI notice will let the individual know that they have 90 days to provide documentation (proof).

An individual will be determined conditionally eligible for coverage and financial assistance during this 90-day "reasonable opportunity" period based on their attestation, pending submission and verification of the requested documentation. For income-related RFIs, if the 90-day reasonable opportunity period is not sufficient for the applicant to obtain and submit the required documentation, BeWell will automatically grant the applicant a 60-day extension for the documentation submission.

If, after the 90-day reasonable opportunity period and/or the automatic 60-day extension, BeWell remains unable to verify the information attested to because the requested information was not received, the individual will be determined ineligible for a QHP and/or financial assistance, as applicable. An individual and/or their tax household may lose all or partial eligibility for coverage and/or financial assistance.

If an applicant does not have documentation to resolve their inconsistency

because it does not exist or is not reasonably available, except for an inconsistency related to citizenship or immigration status, BeWell may provide exceptions on a case-by-case basis and may accept an applicant's attestation for the information that cannot be verified, along with an explanation of circumstances as to why the applicant does not have documentation.

## 6.2 Open Enrollment Period (OEP)

45 CFR 155.410

BeWell will offer an OEP consistent with federal requirements for individuals to apply for health coverage for Plan Year 2027. The OEP for Plan Year 2027 is November 1, 2026, through January 15, 2027.

### 6.2.1 Coverage Effective Dates During the OEP

During the OEP, a household must select a plan for enrollment and make their first month's premium payment (the "binder" payment) no later than December 31 for coverage to begin January 1. Individuals who select a plan for enrollment between January 1 and January 15, and pay their first month's premium by their carrier's due date, will receive a coverage effective date of February 1.

*Table1: Coverage Effective Dates*

| Plan Selection | Coverage Effective Date |
|---|---|
| November 1 – December 31 | January 1 |
| January 1 – January 15 | February 1 |

An enrollee may change their plan selection during the OEP. A consumer who is enrolled in effectuated January coverage and changes their plan selection between January 1 and January 15 will keep their coverage under the first plan for January only.

# 7 Special Enrollment Periods and Qualifying Life Events

45 CFR 155.420

Individuals may apply for coverage through a Special Enrollment Period (SEP) if they experience a Qualifying Life Event (QLE).

**Note:** This policy manual contains basic information about SEPs and qualifying life events. Further information, including a detailed SEP matrix, can be found on the BeWell website.

## 7.1 Qualifying Life Event

A qualifying life event (QLE) is a change in an individual's situation, like having a baby or losing health coverage, that can make the individual eligible for an SEP, allowing them to enroll in coverage outside the annual OEP.

There are four basic types of QLEs:

- Loss of health coverage (e.g., losing job-based insurance or Medicaid);
- Changes in household (e.g., getting married or having a baby);
- Changes in residence (e.g., moving to New Mexico); and
- Other QLEs (e.g., becoming a U.S. citizen or no longer being incarcerated).

Individuals must attest that the information they provide on the application is true, including the circumstances that qualify them for an SEP. They may be required to submit documents to confirm their eligibility to enroll based on the applicable QLE.

## 7.2 Loss of Medicaid SEP

42 U.S.C. 1396a(xx)(7)(B)

BeWell has implemented an extended SEP for individuals who lose Medicaid coverage. To qualify for the SEP, consumers must have been enrolled in, and then determined ineligible for, Medicaid. This SEP is available for 120 days from the last day of Medicaid coverage. Based on information received from HCA that confirms they have lost, or will lose, Medicaid, the system automatically provides a 120-day shopping window from the last day of Medicaid coverage.

Consumers who have been notified by HCA that they are no longer eligible for Medicaid and do not have other sources of coverage should apply for Marketplace coverage through BeWell as soon as possible. Consumers can report a coverage loss up to 60 days in advance.

Beginning in Plan Year 2027, Medicaid beneficiaries who lose their Medicaid coverage due to failure to meet the community engagement will be treated as having lost their coverage for procedural reasons. This means they will be ineligible for federal and state financial assistance. They will, however, qualify for the Loss of Medicaid SEP to purchase a QHP without financial assistance.

## 7.3 Medicaid Denial SEP

45 CFR 155.420(d)(11)

A Medicaid denial SEP exists for applicants who are unable to complete the enrollment process begun during the OEP or a QLE-based SEP, such as a move

or a birth, due to a delayed full Medicaid determination. To qualify for the SEP, a consumer must have:

- Initially applied for BeWell coverage during the OEP or through an SEP due to a QLE; **and**
- Been referred to HCA because they were found to be potentially eligible for Medicaid; **and**
- Been ultimately determined ineligible for Medicaid by HCA outside of the OEP or the SEP; **and**
- Been otherwise eligible for BeWell coverage.

Consumers who apply and are found ineligible for Medicaid alone will not qualify for this SEP; they must have been eligible to apply for BeWell coverage first – through the OEP or another SEP – and missed the window to enroll as they were awaiting a full Medicaid determination that resulted in a denial.

## 7.4 Easy Enrollment

New Mexico's Easy Enrollment Act leverages the state income tax system to make it easy for uninsured New Mexicans to find and enroll in quality affordable health coverage. Easy Enrollment allows New Mexico residents to start the health insurance enrollment process by checking a box on their state income tax return. By checking the box, taxpayers give the state tax agency permission to share relevant information used to assess eligibility for low-cost or no-cost health coverage with HCA, which oversees Medicaid, and with BeWell. Information for those who are not eligible for Medicaid will be transferred from HCA to BeWell. BeWell will notify these individuals that they can continue their application for health coverage at the BeWell website.

Individuals who "checked the box" on their state income tax return to indicate they need health coverage will receive an automatic SEP to enroll in Marketplace coverage. If an SEP is not automatically provided, applicants can request the SEP and provide a copy of their state tax return to demonstrate that they "checked the box."

## 7.5 Effective Dates of Coverage When Enrolling Through an SEP

Changes to enrollments will be effective in accordance with the coverage effective dates based on enrollment, except in the case of court order, birth, adoption, or placement for adoption or foster care, as described below. A change in APTC and/or CSR will also be effective as of the coverage effective date.

A consumer who enrolls in a new plan may choose among the following effective dates of coverage:

- The first of the month following the reported change (if enrollment is completed by the last day of the month in which the change is reported); or
- The first of the second month following the reported change; or
- As applicable, the date of birth, adoption, placement for adoption or foster care, etc. Consumers may also choose a coverage effective date of the 1st of the month following the event. Enrollees should call BeWell at 1-833-862-3935 (TTY: 711) for help.

BeWell also offers earlier coverage effective dates for consumers attesting to a future loss of MEC. This allows the consumer to avoid a gap in coverage. Example: If a consumer attests between May 16 and June 30 that they will lose other MEC on July 15, and selects a plan on or before June 30, coverage may be effective on July 1.

Consumers who apply with BeWell after losing Medicaid coverage can request a retroactive effective date of coverage, back to the first day of the month in which the consumer enrolls in a plan. For example, if a consumer loses Medicaid on July 31, and selects a Marketplace plan on August 25, coverage can start on August 1.

Consumers who qualify for the Loss of Medicaid SEP as well as another SEP will be given the coverage effective date associated with the Loss of Medicaid SEP, unless another SEP allows the consumer an earlier coverage effective date.

## 7.6 Reporting Requirements for Qualifying Life Events

Qualifying life events must be reported to BeWell within 60 days of the event. BeWell may require documents proving that the qualified individual, enrollee, or dependent has experienced one or more qualifying life events.

Applicants must provide documents to confirm certain QLEs. Certain QLEs must be verified before an SEP is opened.

**Note:** Loss of MEC can be reported 60 days prior to the event.

## 7.7 Getting Assistance

BeWell will help individuals and families apply for and enroll in coverage. Individuals may also apply for and enroll in coverage with a licensed and certified insurance broker, or certified enrollment counselor. For information about assistance, please visit the BeWell schedule an appointment page.

## 7.8 Enrollment Completion and Effective Dates

BeWell does not process premium billing on behalf of carriers. Instead, BeWell enrollees must pay their binder payment and monthly premiums directly to their

plan's carrier to start and continue their coverage.

In order to start your coverage (or "effectuate"), enrollees must pay the first month's premium payment (the "binder" payment) in accordance with their carrier's policies and deadlines. BeWell may, at its discretion, request that a carrier accept an individual's enrollment request with a retroactive effective date in certain circumstances, such as when individuals transition from Medicaid to Marketplace coverage via a Loss of Medicaid SEP.

An applicant who fails to complete the enrollment process outlined above by the last day of the month before coverage may select a later effective date of coverage if they do so within the annual OEP or an applicable SEP. If an applicant fails to complete the enrollment process within the OEP or SEP, their enrollment will be canceled.

An individual must comply with BeWell's reasonable requests for information necessary to verify the information attested to on the application to maintain enrollment in a plan.

# 8 Termination of Coverage

45 CFR 155.430

Termination of Marketplace coverage may be either voluntary (i.e., initiated by the enrollee) or involuntary (i.e., initiated by BeWell or, in limited circumstances, the enrollee's carrier). If an enrollee's coverage is terminated, the health plan must cover the enrollee and the covered services that the enrollee received from the coverage effective date until the termination date. An enrollee may voluntarily end their medical coverage without terminating their dental coverage or terminate their dental coverage without terminating their medical coverage. A termination can be effective in the future (e.g., a termination requested by the enrollee up to 60 days before the termination date), or retroactively (e.g., termination due to death or a failure to pay premiums due by the end of a grace period).

## 8.1 Voluntary Termination

An enrollee may voluntarily terminate their insurance coverage for any reason at any time. However, a member who voluntarily terminates their coverage is not eligible to re-enroll in coverage through BeWell until the next OEP, unless they qualify for an SEP, or are an American Indian or Alaska Native. A member can request voluntary termination of coverage through their online account or by contacting BeWell. The termination date is always the last day of the month for which the termination is requested.

## 8.2 Termination Due to Death

An enrollee's coverage may be terminated if the enrollee dies during the plan year. The enrollee's death may be reported by an applicant or their household members who were included in the initial application and who are at least 18 years old. The death can be reported through the member's online account or by calling BeWell at 1-833-862-3935 (TTY: 711). A household member who does not have access to the online account can initiate termination of the deceased's coverage by calling BeWell.

If the Head of Household dies during the plan year, the remaining household members will be eligible for an SEP based on loss of MEC. They must create a new account to enroll in new coverage. The deceased Head of Household should be included in this new account (as a dependent, not as the new Head of Household) for tax purposes for the rest of the plan year.

The documentation below must be submitted to BeWell:

- Copy of official death certificate; or
- Statement from someone qualified to attest to the death, such as a coroner or licensed funeral director.

## 8.3 Termination Due to Fraud

45 CFR 147.128

BeWell or the health plan carrier may terminate or rescind an enrollee's coverage if the carrier identifies an enrollee performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact in connection with the enrollee's coverage. The health plan must provide 30 days advance written notice to each enrollee or participant affected by the intended termination.

In cases of fraud, the effective date of the termination may be retroactive. Further, as allowed by state law, the health plan carrier may deny medical or dental claims not yet received but incurred after the retroactive effective date of termination and reverse any paid medical or dental claims incurred after the retroactive effective date of termination.

The health plan carrier will refund any premiums paid by the enrollee for the period after the retroactive termination date, and CMS will recoup any APTC paid for that period. The carrier will provide the enrollee notice of the termination. If a carrier rescinds coverage for fraud, and in the next OEP the enrollee enrolls in the same plan that was rescinded due to fraud, the carrier must accept the enrollment.

Carriers may rescind coverage only in cases of fraud or intentional misrepresentation of material fact. Carriers can use a support request to initiate a

rescission as described in this section.

## 8.4 Retroactive Termination

An enrollee (actively enrolled or previously terminated) may request to have their policy, or a household member's coverage, retroactively terminated. All retroactive termination requests must be submitted to and approved by BeWell. BeWell defines retroactive termination as a termination with an effective date before the current month.

BeWell will allow retroactive terminations in the following circumstances:

- The individual obtained or was enrolled in other MEC.
- The individual demonstrates to BeWell that they attempted to terminate their enrollment and experienced a technical error that did not allow them to terminate their enrollment through BeWell.
- The individual demonstrates to BeWell that their enrollment was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of BeWell, its instrumentalities, or a non-BeWell entity providing enrollment assistance or conducting enrollment activities.
- The individual demonstrates to BeWell that they were enrolled in a health plan without their knowledge or consent by any third party, including third parties who have no connection to BeWell.
- The notification of the death of an individual by a household member or authorized representative. Documentation is required to be submitted to BeWell before processing the termination in the system.

The individual must request retroactive termination within 60 days of discovering the circumstance. Requests for retroactive termination outside of these circumstances will be reviewed and approved or denied at the sole discretion of BeWell.

Effective dates for retroactive termination of coverage:

- The last day of the coverage month before the member is eligible for other MEC; or
- The day before the QHP or QDP policy effective date if the individual was enrolled in error or without their knowledge; or
- The date of death.

## 8.5 Enrollee Age-Out

BeWell conducts enrollee age-out throughout the year as specified below.

### 8.5.1 Pediatric Only Dental Plans

A member's eligibility for pediatric dental benefits ends at the end of the plan year in which the enrollee attains 19 years of age. The household can choose a different dental plan for the following plan year during the annual OEP.

### 8.5.2 Dependents on Family Medical and Dental Plans

A dependent's enrollment will be terminated the last day of the year in which the dependent attains 26 years of age. The enrollment will not automatically terminate if the individual aging out is the subscriber, the subscriber's spouse, or domestic partner. A dependent enrollee who is disabled will not experience changes in enrollment because of attaining 26 years of age.

# 9 Financial Management and Premium Billing

BeWell does not process premium billing on behalf of carriers. Instead, BeWell enrollees must pay their binder payment and monthly premiums directly to their plan's carrier to start and continue their coverage.

This section details the policies, procedures, and rules governing the following for the individual Marketplace:

- Premium Billing
- Premium Payments
- Non-payment of Premium and Terminations
- Refunds
- Returned Payments

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## 9.1 Premium Billing Details

Carriers will send enrollees premium bills directly. These communications should include the subscriber's name and ID, plan, carrier, coverage month, due date, premium amount, any APTC amount applied to the premium (if applicable), and any outstanding balance. They should also include any Marketplace Affordability Program (MAP) amount applied to the premium. The total amount due is summarized and reduced by the APTC and MAP amounts.

Each premium bill should also include a list of all enrolled dependents for the coverage month. If a subscriber has enrolled in recurring payments, their bill should include a message indicating their payment will be withdrawn from the subscriber's bank account or credit/debit card on file.

## 9.2 Premium Payments

### 9.2.1 Premium Payment Threshold

45 CFR 155.400(g)

BeWell requires carriers to adhere to a premium payment threshold policy. This policy allows an enrollee to make a payment that is less than the premium, but within the “threshold” amount. The policy considers a payment to have been made in full once the payment(s) received are equal to or greater than the threshold.

Carriers may establish a threshold percentage in accordance with federal law. For Plan Year 2027, carriers may use a threshold based on an enrollee’s net premium. The policy does not apply to the initial premium payment (the binder payment), but may apply to ongoing premium payments.

### 9.2.2 Initial Payment (the “binder payment” or “binder”)

45 CFR 155.410; 45 CFR 155.420

Enrollees must make their binder payment directly to their health plan carrier to complete their enrollment and for coverage to be effectuated. The binder payment must be equal to the first month's full premium, minus any financial assistance that has been applied.

### 9.2.3 Binder Payment Due Dates

Binder payments must be received by the due date for coverage to begin. There are no grace periods for binder payments. The binder payment must be paid in full by the effective date of the coverage or 30 days from the day the enrollment is received, whichever is later.

### 9.2.4 Ongoing Payments

Carriers should maintain and communicate their own policies for ongoing premium payments, which must be applied uniformly to their plan enrollees. To maintain continuous coverage, enrollees should refer to their carriers' premium payment policies to ensure they understand deadlines by which they must pay their monthly premium to continue their coverage, policies around any outstanding premium balance, and how and when changes to their account may impact their bill. Carriers must provide for payment grace periods in accordance with Section 8.4 of this policy manual.

### 9.2.5 Payment for Renewals

For renewals, a binder payment is not required as the renewal is a continuation of coverage, and no new effectuation is required. This includes re-enrollments in another plan within the same product, or in a different plan in a different product offered by the same carrier.

### 9.2.6 Payment Types

Subscribers can choose to make one-time payments or enroll in recurring payments. Carriers must accept the following payment types.

*Table 2: Payment Types*

| Payment Method | One Time | Recurring |
|---|---|---|
| Personal Checks | X | |
| Cashier's Checks | X | |
| Money Orders | X | |
| Electronic Funds Transfer (EFT) | X | X |

Carriers may also accept debit and credit cards for one-time and/or recurring premium payments; BeWell strongly encourages carriers to accept these payment methods.

### 9.2.7 Direct-to-BeWell Payments

BeWell does not accept premium payments through the BeWell platform. Instead, members must make their premium payment directly to their carriers. Members should contact their carriers for guidance on how to make payments online, by phone, or by mail.

## 9.3 Grace Periods

Subscribers have a grace period before their coverage can be terminated for non-payment.

### 9.3.1 Grace Period Window

45 CFR 155.430; 45 CFR 156.270(d) and (g)

If a health plan carrier has not received premium payment on or before the first day of the coverage month, a grace period is triggered. The grace period is

different for enrollees who receive APTC or other state financial assistance:

- With APTC and/or state financial assistance, the grace period is 90 days
- Without APTC or state financial assistance, the grace period is 31 days or to the end of the month, whichever comes first

Partial payments will not adjust a grace period. A subscriber who is eligible for APTC, but who elects not to receive the credit in advance, will not receive a 90-day grace period. The 90-day grace period only applies to enrollees who are receiving an APTC and/or state financial assistance.

Note: There is a 90-day grace period for QDP enrollment only when the member is enrolled in a QHP with APTC. The 31-day grace period applies to dental policies with no APTC (e.g., stand-alone dental plans).

### 9.3.2 Payment of Claims Incurred During the Grace Period

For enrollees receiving APTC, carriers must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period, and may pend claims for services rendered to the enrollee in the second and third months of the grace period. Carriers must notify providers of the possibility of denied claims when an enrollee is in the second and third months of the grace period.

If the enrollee's coverage is terminated for non-payment of premiums retroactively to the last day of the first month of the grace period, the carrier may deny any claims that were pended for services received during the second and third months of the grace period. However, the carrier cannot retroactively deny claims from the first month of the grace period. Any premium a carrier receives for coverage beyond the retroactive termination date will be refunded to the subscriber.

## 9.4 Non-Payment of Premium and Notices

If a carrier has not received premium payment by the due date, a grace period is triggered for the subscriber and generates a series of notices throughout the grace period. The types and frequency of notices are based on whether a subscriber is receiving APTC.

Below is an example of the timeline for non-payment of premium for both APTC and non-APTC enrollment for a May coverage month:

*Table 3: Timeline for Non-Payment APTC and State Subsidy Enrollment Example*

| May Coverage<br>Payment Due 4/30 | |
|---|---|
| May 1 | Late Notice 1 |
| June 1 | Late Notice 2 |
| July 1 | Late Notice 3 |
| August 1 | Termination Notice<br>Termination processed effective 5/31 |

*Table 4: Timeline for Non-Payment Non-APTC Enrollment Example*

| May Coverage<br>Payment Due 4/30 | |
|---|---|
| May 1 | Late Notice |
| June 1 | Termination Notice<br>Termination Processed Effective 4/30 |

### 9.4.1 Late Notice

A Late Notice from the carrier informs the subscriber that their premium payment has not been received and they must remit payment to avoid termination for non-payment of premium. The notice should include the grace period, coverage month(s) outstanding, the amount due, and the due date. The notice should also include coverage months billed since the grace period began.

### 9.4.2 Termination Notice

A Termination Notice sent by the carrier informs the subscriber that their policy has been terminated. The notice should include the termination effective date and reason for termination.

Once an individual's plan has been terminated, they are not able to re-enroll in a Marketplace plan until the next OEP, unless they qualify for an SEP in the interim. Loss of coverage due to non-payment of premiums is not considered a Qualifying Life Event to trigger an SEP.

### 9.4.3 Termination for Non-Payment of Premium

45 CFR 155.430(b)(2)(ii); 45 CFR 156.270(g)

A carrier will terminate an enrollee's coverage for non-payment of premiums if payment is not made in full by the end of the grace period. The termination process is initiated on the first of each month. The policy is retroactively terminated, and the termination effective dates are as follows:

- For subscribers receiving APTC: Termination effective date is the last day of the first month of the grace period (e.g., non-payment for May coverage is terminated effective May 31).
- For subscribers not receiving APTC: Termination is effective the last day of the coverage month for which the last payment was made in full (e.g., non-payment for May coverage is terminated effective April 30).

To avoid termination, an enrollee must pay all outstanding premiums in full, or within the premium payment threshold, before the end of the grace period. The acceptance of any partial payment does not establish a waiver of rights to terminate an enrollee for non-payment of premiums and does not "reset" a grace period.

A subscriber whose policy was terminated for non-payment is not able to re-enroll in coverage through BeWell until the next OEP, unless they qualify for an SEP. Loss of coverage for failure to pay premiums does not qualify for an SEP. However, if the enrollee becomes eligible for an SEP based on other circumstances, the enrollee may enroll in a new plan or a plan from which the coverage was terminated for non-payment.

During the annual OEP, enrollees whose coverage was terminated for non-payment of premiums before the end of the plan year will be able to apply for an eligibility determination, and, if determined eligible, will be permitted to enroll in coverage for the new plan year.

## 9.5 Past-Due Premiums and Effectuation

Following a federal district court decision issued June 12, 2026, carriers are prohibited from requiring the payment of past-due premiums to effectuate new coverage.

# 10 Reporting Changes and Redeterminations

45 CFR 155.335

BeWell is required to redetermine eligibility for Marketplace health insurance coverage, as well as any federal or state financial assistance (if applicable), for an enrollee and

their dependent(s) based upon a change to any eligibility criteria. This includes information reported by the enrollee or obtained by BeWell through periodic data matching during the plan year. A change reported by the enrollee may need to be verified before it is finalized, including by ensuring that the information provided is consistent with the records of BeWell (i.e., BeWell was able to confirm the change by matching with electronic data sources), or that the enrollee has provided documentation to support the change. If a change cannot be verified, BeWell must redetermine eligibility based on other information it has.

## 10.1 Enrollee Responsibility

45 CFR 155.335(e)

An enrollee and the dependent(s) must report any changes that impact eligibility for coverage through BeWell and/or financial assistance within 30 days of the event.

## 10.2 Reporting Changes

Enrollees must report changes related to:

- Family size or composition due to birth, adoption, placement for adoption or foster care, marriage, divorce, death, etc.;
- Residency, including a change to a residential and/or mailing address;
- Citizenship, nationality, lawful presence, or status as an eligible noncitizen;
- Native American status (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. §450b(d)); and
- Incarceration status.

The same channels for submitting applications – online, over the phone, by mail, or with an assister – are also available for reporting changes.

## 10.3 Reporting Changes for Enrollees Receiving Financial Assistance

- Only individuals who requested an eligibility determination for financial assistance (e.g., APTC) are required to report changes within 30 days related to:
    - Eligibility determination for or enrollment in other health insurance, including Medicare, Medicaid, other government-sponsored health insurance, or employer-sponsored coverage;
    - Income; and
    - Employment status, including any change in eligibility for employer-sponsored insurance.

**Note:** BeWell will reassess eligibility for enrollees who report changes. A new eligibility determination may result in changes to the enrollee's premium and/or financial assistance amounts.

There are no caps on excess APTC amounts the federal government can require to be repaid. Enrollees should promptly report any changes that may affect their APTC eligibility to BeWell to avoid needing to repay excess APTC when they file their taxes.

## 10.4 Changes Found During Data Matching Process

45 CFR 155.330(d)

BeWell is required to periodically check data of enrollees who are receiving APTC If BeWell identifies updated information through data matching, it will notify the enrollee and provide them at least 30 days to provide their own updated information.

- If the enrollee confirms the information in the notice, their eligibility will be updated in accordance with the effective dates outlined in the notice.
- If the enrollee provides different information, BeWell will verify the information provided by the enrollee and update eligibility in accordance with the effective dates outlined in section 10.5, Effective Dates for Changes.
- If the enrollee does not respond to the notice, BeWell will update the eligibility using the information collected via data matching at the end of the month in which the 35th day after mailing occurs (or as specified in the notice).

## 10.5 Effective Dates for Changes

Changes will be effective as follows: Changes that result in an individual no longer being eligible for a health plan will be effective at the end of the month in which the determination occurs, except for terminations due to death.

An enrollee who reports a change in income that results in an assessment by BeWell that the enrollee is likely eligible for Medicaid may remain eligible for Marketplace coverage pending a Medicaid de0termination by HCA. Thereafter:

- If the new household income is at or above 100% of the federal poverty level, and if the enrollee is otherwise eligible for financial assistance, the enrollee may receive APTC and other cost savings at the new income level until their income has been verified.
- If the new household income is below 100% of the federal poverty level, the enrollee may receive their current level of financial assistance through the end of the month following the month of the reported change, after which time the individual will become eligible for unsubsidized coverage

until their income is verified.

- If determined eligible for Medicaid by HCA, enrollees may choose to end their Marketplace coverage. Enrollees who do not choose to end their coverage may remain eligible for and enrolled in their Marketplace coverage, but without financial assistance. The enrollee will be responsible for the full cost of the health plan purchased through BeWell.

**Note:** A consumer can request on their BeWell application that their Marketplace coverage be terminated automatically if they are determined eligible for Medicaid by HCA. This helps the consumer avoid dual coverage in Medicaid and through BeWell.

# 11 American Indian and Alaska Native (AI/AN) Individuals and Families

25 U.S.C. §450b(d); 45 CFR §155.350

There are special provisions for AI/AN individuals and families regarding eligibility, enrollment, and cost-sharing. An AI/AN individual is defined as a person who is a member of a federally recognized tribe.

The following policies apply only to federally recognized AI/AN individuals who want to enroll or have enrolled in a health plan through BeWell.

## 11.1 Rule Regarding Enrollment for American Indian/Alaska Natives

45 CFR 155.420(d)(8)

An AI/AN individual must meet all eligibility and enrollment criteria to enroll in health coverage through BeWell. An AI/AN individual may enroll in a health plan, and/or may change their health plan up to once per month, throughout the plan year.

## 11.2 Cost-Sharing Reductions (CSR) for American Indian/Alaska Natives

Additional CSR are available to American Indians/Alaska Natives (AI/AN).

- An AI/AN consumer enrolled in a Marketplace plan will not be responsible for any cost-sharing requirement for an item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contracted health

services.

- An AI/AN consumer who is eligible for a Marketplace plan with a premium tax credit, and who has a household MAGI between 100% and 300% of the FPL, can choose a zero cost-sharing plan. This means the consumer will not have any out-of-pocket costs, such as deductibles, co-pays, or co-insurance, when getting essential health benefits through a Marketplace plan. These consumers can enroll in a limited cost-sharing plan at any level.
- An AI/AN individual enrolled in a Marketplace plan with an income below 100% or 300%-400% of the FPL can choose a plan with limited cost-sharing. This means the consumer does not have to pay co-payments, deductibles, or co-insurance when getting care from an Indian health care provider. They do, however, need a referral from an Indian health care provider when getting essential health benefits through a Marketplace plan to avoid paying co-payments, deductibles, or co-insurance.

# 12 Appeals, Complaints and Grievances

## 12.1 Appeals

45 CFR 155.500 – 45 CFR 155.555

An applicant or enrollee has the right to appeal certain decisions or determinations made by BeWell. An applicant or enrollee may appeal the following decisions:

An eligibility determination, including:

- An initial determination of eligibility, including the amount of APTC and level of CSR;
- A redetermination of eligibility, including the amount of APTC and level of CSR;
- A determination of eligibility for a special enrollment period; or
- A failure by BeWell to provide timely notice of an eligibility determination.

Individuals have 90 days from the date of their eligibility notice to file an appeal on any issue listed above. Individuals can submit an appeal by following the instructions at https://bewellnm.com/appeals/BeWellnm.com/appeals. BeWell will work to informally resolve appeals. Should an appeal require formal adjudication, the appeal will be heard by HCA's Office of Fair Hearings for a final determination. HCA will issue written notice of the appeal decision within 90 days of the date an appeal request is received.

Individuals seeking assistance with filing an appeal may visit the BeWell website or call BeWell at 1-833-862-3935 (TTY: 711).

## 12.2 Complaints and Grievances

Individuals may also file a complaint or grievance with BeWell about Marketplace operations. Complaints may be submitted through the customer's online account or via chat on BeWellnm.com. Individuals may submit a complaint by calling BeWell 1-833-862-3935 (TTY: 711). BeWell will review all complaints upon receipt. BeWell will transfer complaints it receives that should be directed to another party (e.g., a complaint that a carrier denied benefits) to that party, and will do so by secure electronic communication, as appropriate.

# 13 Renewals

A household enrolled in Marketplace coverage will have their coverage renewed prior to the annual OEP. The current year coverage will end on December 31, and the renewal coverage will typically start on January 1.

A qualified individual or family whose coverage started after January 1 will have a plan year of less than 12 months and will have their coverage renewed during the annual OEP for coverage effective on January 1.

## 13.1 Automatic Renewals

45 CFR 155.335; 45 CFR 156.290(5); 45 CFR 155.430

BeWell will automatically renew an enrollee's medical and/or dental insurance coverage for the next plan year if the enrollee is determined eligible to enroll in coverage.

BeWell will update a household's information for the renewal year prior to the annual OEP and send a renewal notice and an eligibility notice to the Head of Household. The eligibility notice will contain eligibility information (e.g., program eligibility, tax credit information) for the coming plan year. If the household's information is correct, and they do not have any changes to report, they do not have to take any action. The household may update their information for the renewal year during the annual OEP. Members of the household who are eligible for the next plan year will be renewed into the same or similar ("mapped") plan and notified through the renewal notice. Enrollees may elect a different plan, as described in the renewal notice.

Individuals who are no longer eligible to purchase coverage through BeWell will not be renewed into coverage for the new plan year, and will be notified that their coverage will not be renewed. Individuals can reapply and enroll in coverage, if eligible, during the annual OEP.

#### 13.1.1 Silver to Gold Plan Mapping

BeWell will renew members who are currently enrolled in a Silver level plan into a Gold level plan when the following requirements are met:

- The consumer would otherwise be automatically re-enrolled in either a -01 or -04 Silver variant; and
- The consumer is guaranteed to have access to a Gold plan offered by their current issuer that has:
    - An identical provider network as the plan into which they would otherwise be enrolled;
    - An identical drug formulary as the plan into which they would otherwise be enrolled; and
    - Has a lower premium than the Silver plan into which they would otherwise be automatically re-enrolled.

### 13.2 Cross-Walked Renewals When a Carrier Leaves the Marketplace

If an insurance carrier exits the individual Marketplace or is decertified by BeWell at the end of the plan year, BeWell will terminate that carrier's member enrollments at the end of the plan year. Individuals will be automatically enrolled in a plan with a similar design and premium amount, known as a "cross-walked" plan, as directed by the OSI. Individuals may change plans anytime during the OEP.

Note: If a carrier leaves the individual Exchange before the end of the coverage year, members enrolled in plans issued by that carrier will be eligible for an SEP to select a new plan.

## 14 Dental

### 14.1 Dental Open Enrollment

45 CFR 155.410

For dental coverage purchased with a medical plan, the same OEP and SEPs apply. However, individuals may shop and enroll in a stand-alone dental plan year-round, although they may only change or enroll in a stand-alone dental plan once per month.

### 14.2 Rate Codes

45 CFR 147.102

To determine the dental premium, BeWell will count members of the household that are age 19 or older and the three oldest children who are still 18 years old or younger and add their individual premium amounts together to get the household premium amount.

## 14.3 Pediatric Dental Age Limits

Anyone 18 years of age or under can enroll in a pediatric dental plan.

## 14.4 Disenrollment

Enrollees may terminate their dental coverage without terminating their medical coverage. Those enrolled as dependents in a dental policy which includes adult coverage will be automatically disenrolled at the end of the year in which the member turns 26.

## 14.5 Dental Renewals

45 CFR 155.335(j)

Dental insurance plans will be renewed for enrollees during the OEP.

## 14.6 Applying Leftover APTC to a Dental Plan

45 CFR 155.340; 26 CFR 36B-3(e)

APTC may not be applied to a dental plan, unless there is remaining APTC after being applied to the medical plan and the subscriber is also enrolled in a stand-alone dental plan with pediatric dental benefits.

Leftover member-level APTC will be carried forward from the medical plan to the dental plan if the following conditions are met:

The member has selected a medical plan and:

- the member-level leftover APTC after medical plan shopping is greater than $0;
- the maximum possible APTC has been applied towards the essential health benefits portion of the medical plan;
- The consumer has not selected a medical plan with pediatric dental benefits; and
- There is at least one minor (under 19 years of age) member in the dental plan shopping group.

## 14.7 Qualified Dental Plans

Individuals may shop for and purchase a standalone dental plan without purchasing a medical plan. The applicant must be determined eligible by BeWell to purchase a dental plan. Individuals may shop for and enroll in a stand-alone dental plan year-round.

**Note:** APTC is not applicable to stand-alone dental plans.

**Note:** Eligibility is dependent on citizenship status, New Mexico residency, and not being incarcerated.

# 15 Tax Reporting

Individuals who are enrolled in a health plan through BeWell and who use APTC to lower their monthly payments are required to "reconcile" when filing their federal taxes. Individuals will receive IRS Form 1095-A, *Health Insurance Marketplace Statement*, from BeWell. The Form 1095-A provides individuals with information about their health insurance coverage so that application tax filers can:

- File a federal tax return for the coverage year;
- Reconcile APTC; and
- Claim the PTC if they have not taken the full amount in advance.

Individuals will get one Form 1095-A for each plan in which they or members of their household were enrolled during the tax year. They may receive multiple forms if they:

- Changed plans in the middle of the year; and/or
- Added or removed members from a plan during the year.

## 15.1 Form 1095-A

In January of each year, BeWell mails IRS Form 1095-A, *Health Insurance Marketplace Statement*, to tax filers who enrolled in a health plan through BeWell during the prior year, except for those enrolled in dental-only plans. The Form 1095-A is also generated electronically and posted to the tax filer's online account.

Individuals will use the information provided on Form 1095-A to complete IRS Form 8962, Premium Tax Credit. Application tax filers must complete and file a Form 8962, regardless of whether they are required to file a tax return, if they received APTC.

BeWell also provides the IRS with monthly and yearly data regarding all individual enrollment and APTC payments made to QHP carriers on behalf of enrollees. The IRS uses this data when processing individual federal income tax returns (for example, to reconcile APTC, process PTC claims, and grant exemptions). Annual reports are submitted to the IRS at the end of the coverage

year, identifying tax filers or other relevant adults who received APTC (or whose tax dependent(s) received APTC) related to an individual policy purchased through BeWell. The IRS uses the information in the annual report to verify information on the tax filer's Form 8962. Please visit IRS Forms, Instructions, and Publications for complete IRS instructions.

If an individual did not receive Form 1095-A or has questions regarding the information on Form 1095-A they should contact BeWell at 1-833-862-3935 (TTY: 711).

Enrollees are not required to reconcile NMPA and NAPA payments on their coverage year tax returns as they do for APTC.

# 16 Notices

Notices will be sent by U.S. mail or electronically (via secured inbox) based on the communication preference selected by the individual. The table below provides a general description of the notices that BeWell may send.

*Table 5: BeWell Notices*

| Notice Name | Notice Details |
|---|---|
| **Account Transfer** | The inbound/outbound response Account Transfer notice informs the Head of Household that they need to take required action so that they can be determined/re-determined for their household's eligibility for a Marketplace plan (also known as a Qualified Health Plan, or QHP). |
| **Appeal Acknowledgement** | The Appeal Acknowledgment notice acknowledges receipt of an appeal submission to BeWell and informs the user of next steps. It also includes information on whether an appeal was timely submitted and/or involves an issue that is not subject to appeal. |
| **Appeal Decision (Informal)** | The Appeal Decision (Informal) notice informs the appellant of BeWell's informal resolution of the appeal. The notice also provides instructions for requesting a hearing if the appellant disagrees with the informal decision. |

| Notice Name | Notice Details |
|---|---|
| **Appeal Request for Information (RFI)** | An Appeal RFI notice is sent to request additional information that may be needed to resolve the appeal. |
| **Communication Preference Change** | The Communication Preference Change notice informs the member of their change in communication preference. |
| **Eligibility Notice** | The Eligibility notice informs the applicant of the eligibility determination, including conditional eligibility, for a Marketplace plan and/or financial assistance, along with other benefits. The notice is triggered at the tax household level. An eligibility notice is sent for any redetermination, including at renewal. |
| **Periodic Data Matching (PDM)** | The Periodic Data Matching notice is used to notify a health plan enrollee that there may be a change in or termination of existing benefits due to information received during the PDM process. |
| **Pre-renewal Notice** | The Pre-renewal notice will be used to notify enrollees of the upcoming Open Enrollment Period and renewal and redetermination process. |
| **Renewal Notice** | The Renewal notice will be used to notify the household of their enrollment information for the upcoming plan year |
| **Request for Identity Proof (RIDP)** | RIDP is the process of validating sufficient information that uniquely identifies an individual (e.g., credit history, personal demographic information, and other indicators). Individuals must be identity proofed to gain access to the BeWell online application. BeWell uses the Experian identity verification system (Experian) to remotely perform identity proofing. |
| **Request for Information (RFI)** | The Request for Information notice is sent to the recipient when there is unverified |

| Notice Name | Notice Details |
|---|---|
| | data on file for an eligibility on an applicant. It may request proof of SSN, citizenship, income, or incarceration status, for at least one individual identified on an application. |
| **Request for Information (RFI) Reminder** | This notice reminds the recipient to provide the documentation requested in the RFI notice to verify the recipient's eligibility application information. |
| **Special Enrollment Period Decision** | The Special Enrollment Period Decision notice is sent to the recipient when there is an SEP determination, including whether the household is eligible or ineligible for the SEP. It may also request additional information necessary to verify eligibility for the SEP. |
| **Tax Liability (Employer)** | The Tax Liability notice informs the employer that their employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions through BeWell. BeWell is not currently sending Tax Liability notices. |

# 17 Appendix: Terms and Acronyms

*Table 6: Terms and Acronyms*

| Term | Acronym | Definition |
|---|---|---|
| **Account Holder** | None | An individual who initially creates an account with BeWell, whether individually or with the help of a customer service representative. |
| **Adjusted Gross Income** | AGI | Total (or “gross”) income for the tax year, minus certain allowed adjustments. Adjustments include deductions for conventional IRA contributions and student loan interest. |
| **Applicant** | None | Any Individual listed on an application. |
| **Authorized Representative** | ARD | Someone an enrollee chooses to act on their behalf with BeWell, such as a family member or other trusted person. Some authorized representatives may have legal authority to act on the enrollee's behalf. |
| **BeWell Customer Service** | None | BeWell’s call center. |
| **Cancellation** | None | When an enrollment ends on or before the date coverage becomes effective resulting in |

| Term | Acronym | Definition |
|---|---|---|
| | | coverage never having been effective. This occurs when an applicant fails to pay their first month's premium (binder payment), and their policy is canceled. Unlike terminations, cancellations do not require prior notification. |
| **Carrier** | None | A carrier, or issuer, is an entity licensed by the New Mexico Office of Superintendent of Insurance (OSI) as an insurance provider and is seeking to offer one or more Qualified Health Plans and/or Qualified Dental Plans (also known as stand-alone dental plans) through BeWell. |
| **Centers for Medicare & Medicaid Services** | CMS | The federal agency that runs Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and the federally facilitated Marketplace (FFM). |
| **Certified Enrollment Counselor** | EC | A person who is trained and certified by BeWell to provide in-person counseling and to assist consumers who need help applying for Marketplace programs. Their services are free to consumers. |
| **Complex Household** | None | An application that includes some members who are eligible for a QHP with tax credits, and some |

| Term | Acronym | Definition |
|---|---|---|
| | | members who are eligible for Medicaid. |
| **Customer Service Staff** | None | An employee of BeWell Customer Service. |
| **Dependent(s)** | None | A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents. |
| **Eligible Noncitizen** | None | A lawfully present noncitizen who is also a lawful permanent resident (LPR) or Green Card holder, a Cuban or Haitian entrant, or a lawful resident of the U.S. under a Compact of Free Association (COFA) with the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), or the Republic of Palau. Noncitizens must meet this definition to be eligible for federal financial assistance. |
| **Employer-Sponsored Insurance** | ESI | Employer-sponsored Insurance (ESI) is purchased through an employer, union, or by a self- employed individual. |

| Term | Acronym | Definition |
|---|---|---|
| **Federal Data Services Hub** | FDSH | The Centers for Medicare & Medicaid Services (CMS) offers a tool called the Federal Data Services Hub (the Hub, or FDSH) that helps verify information used to determine eligibility for enrollment in qualified health plans and insurance affordability programs. The Hub provides one connection to the common federal data sources needed to verify individual application information for income, citizenship, immigration status, access to minimum essential coverage, etc. |
| **Federal Poverty Level** | FPL | A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage. HHS publishes updated FPL numbers in January each year. Once published, the new figures will be used for determining eligibility for Medicaid for 2027. The 2026 FPL income numbers are used to calculate savings on Marketplace insurance plans for Plan |

| Term | Acronym | Definition |
|---|---|---|
| | | Year 2027. |
| **Federal Tax Information** | FTI | Any record, file, transaction, tape, or cartridge received directly from the IRS or the Medicare Coordination of Benefits (COB) contractor that contains a beneficiary or spouse name, SSN, employer name and address, and taxpayer identifier number. |
| **Federally Facilitated Marketplace** | FFM | A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Federally Facilitated Marketplace, available at HealthCare.gov, for most states. Some states, like New Mexico, run their own marketplaces. |
| **Health Care Authority** | HCA | New Mexico's Health Care Authority (HCA) manages state and federal public assistance programs. HCA administers the Medicaid program as well as the integrated eligibility system (ASPEN) used to determine eligibility for those programs. |
| **Health Insurance Portability and** | HIPAA | The Health Insurance Portability and Accountability Act of 1996 |

| Term | Acronym | Definition |
|---|---|---|
| **Accountability Act** | | (HIPAA) was enacted to improve the efficiency and effectiveness of the nation's healthcare system. The law includes provisions to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also defines requirements for the privacy and security of protected health information. |
| **Health Insurance Exchange** | HIX | Also known as the Health Insurance Marketplace. A service that helps people shop for and enroll in affordable health insurance. The federal government operates the federal Marketplace, available at Healthcare.gov, for most states. Some states, like New Mexico, run their own marketplaces. New Mexico's Marketplace is the New Mexico Health Insurance Exchange, also known as BeWell. |
| **Internal Revenue Service** | IRS | A division of the US Treasury Department responsible for ensuring compliance to the Federal Tax Code. |
| **Issuer** | None | See definition of Carrier. |
| **Medicaid** | None | One of the insurance affordability programs |

| Term | Acronym | Definition |
|---|---|---|
| | | addressed in the Affordable Care Act. The New Mexico Health Care Authority (HCA) administers the Medicaid program in the State of New Mexico. |
| **Minimum Essential Coverage** | MEC | Any insurance coverage that meets the Affordable Care Act requirement for having health coverage. Examples of plans that qualify include Marketplace plans, job-based plans, Medicare, and Medicaid. There currently is no penalty for not having minimum essential coverage. |
| **Modified Adjusted Gross Income** | MAGI | The figure used to determine eligibility for the premium tax credit and other savings for Marketplace health insurance plans and for Medicaid and the Children's Health Insurance Program (CHIP). MAGI is adjusted gross income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. |
| **National Producer Number** | NPN | A unique identifier assigned through the National Association of Insurance Commissioner's (NAIC's) licensing application process. The NPN is used to track |

| Term | Acronym | Definition |
|---|---|---|
| | | individuals and business entities on a national basis. |
| **New Mexico Health Insurance Exchange** | NMHIX | The New Mexico Health Insurance Exchange, established by state law in 2013, in accordance with the federal Affordable Care Act, is a marketplace for qualified individuals to shop for and compare health insurance. Qualified individuals may also receive financial assistance (tax credits) to lower the cost of insurance. NMHIX is commonly known as BeWell. |
| **Non-Financial Assistance** | Non-FA | A non-financial assistance application determines eligibility for a Marketplace plan without financial assistance. |
| | | |
| **Office of the Superintendent of Insurance** | OSI | The Office of Superintendent of Insurance (OSI) is the regulatory agency for insurance products in New Mexico. See www.osi.state.nm.us for more information. |
| **Open Enrollment Period** | OE or OEP | The annual period when people can enroll in a health insurance plan without a qualifying event. |
| **Patient Protection and Affordable Care Act** | PPACA | The first part of the comprehensive healthcare reform law enacted on |

| Term | Acronym | Definition |
|---|---|---|
| | | March 23, 2010. The law was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is usually used to refer to the final, amended version of the law. (It's sometimes known as "PPACA," "ACA," or "Obamacare.") The law provides numerous rights and protections that make health coverage fairer and easier to understand, along with financial assistance (through premium tax credits and cost-sharing reductions) to make it more affordable. The law also established state health insurance exchanges. |
| **Periodic Data Matching** | PDM | The process by which health insurance exchanges periodically examine available data sources to identify individuals enrolled in Marketplace health plans with financial help at the same time they're determined eligible for or enrolled in Medicare or Medicare. Generally, individuals who have been determined eligible for or are enrolled in MEC through Medicaid or Medicare are not eligible to receive financial assistance to help pay for |

| Term | Acronym | Definition |
|---|---|---|
| | | a Marketplace plan premium or for covered services. |
| **Personally Identifiable Information** | PII | As defined by the Office of Management and Budget (OMB), information that can be used to distinguish or trace an individual's identity, like their name, Medicare Number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, like date and place of birth, mother's maiden name, etc. |
| **Protected Health Information** | PHI | The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. |
| **Qualified Dental Plan** | QDP | A dental plan certified by the OSI and BeWell to be offered on the Exchange. |
| **Qualified Health Plan** | QHP | An insurance plan that is certified by OSI and BeWell, provides essential health benefits, follows established limits on cost- |

| Term | Acronym | Definition |
|---|---|---|
| | | sharing (like deductibles, co-payments, co-insurance, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act. All QHPs satisfy requirements for minimum essential coverage. All plans sold on the Marketplace are QHPs. |
| **Remote Identity Proofing** | RIDP | RIDP is the process of validating sufficient information about an applicant (e.g., credit history, personal demographic information, and other indicators) to uniquely identify them. |
| **Request for Information** | RFI | A Request for Information (RFI) is a notice sent to the head of household when there is unverified eligibility data on file for an applicant. It may include requests for proof of SSN, citizenship, income, incarceration status, etc., affecting at least one household member's eligibility determination. |
| **Social Security Administration** | SSA | The Social Security Administration (SSA) administers two programs that provide benefits based on disability: the Social Security disability insurance program (Title II of the Social Security Act (Act)) and the Supplemental Security Income (SSI) program |

| Term | Acronym | Definition |
|---|---|---|
| | | (Title XVI of the Act). |
| **Social Security Number** | SSN | The nine-digit Social Security number that is a person's first and continuous connection with Social Security. It helps identify and accurately record covered wages or self-employment earnings. It is also used to monitor a person's record once they start receiving benefits. |
| **Special Enrollment Period** | SEP | A Special Enrollment Period allows an individual or family to apply for and enroll in health coverage outside of the annual Open Enrollment Period, or during the Open Enrollment Period for an earlier coverage start date. |
| **State-based Marketplace or State-based Exchange** | SBM/SBE | States like New Mexico that run a State-based Marketplace are responsible for performing all marketplace functions for the individual market. Individuals in these states apply for and enroll in coverage through marketplace websites established and maintained by the states. |
| **Trusted Data Source** | TDS | The external data source that BeWell uses to verify application data. The TDS is offered through the Federal Data Services Hub (FDSH). |