QLE for Loss of Coverage

Medicaid – Notice of Case Action (NOCA)

- Consumer provides NOCA with a Case Action description which will help determine if their Medicaid eligibility has been denied, closed or changed.

    - **Denial**: Member **submits a new application** and Case Action description states they have been denied. Denial category shows month they were denied for full MA and reason.
        - A denial is **not** a Qualifying Life Event (QLE).
        - If member applied for MA outside of OE and was denied due to high income, age, immigration status, or other – They can be referred to the New Mexico Medical Insurance Pool (NMMIP) at 866-306-1882.

    - **Closure**: Member **did not submit their MA renewal packet** and Case Action description states their MA is closed/termed. Closure category shows month MA was closed/termed and reason. Last day of MA is day before closure month.
        - QLE may be approved if:
            - HH income is **above 138% FPL** (for adults)**,** and full MA closed/termed within the last **120 days**
                - **Below 138% FPL** – Advise member to renew with HCA ISD for proper determination, unless they do not meet immigration status or age requirements for MA.

    - **Change in Benefits**:
        - Member **submits MA renewal but no longer qualify for full MA** due to high income, age or immigration status and Case Action description states their MA has changed. Change in Benefits category shows month MA changed (or ended) and reason. Last day of MA is day before change month.
            - QLE may be approved if:
                - Full MA changed (or ended) within the last **120 days**

        - Member **submits MA renewal but does not provide additional documentation** and Case Action description states their MA has changed. Change in Benefits category shows month MA changed (or ended) and reason. Last day of MA is day before change month.
            - QLE may be approved if:
                - Full MA changed or (ended) within the last **120 days**, and
                - HH income is **above 138% FPL** (for adults)
                    - **Below 138% FPL** – Advise member to send additional documents to HCA ISD for proper determination, unless they do not meet immigration status or age requirements for MA.

- **Loss of Family Planning**
    - Family Planning MA is **not** full MA – Not a QLE

- **Loss of Other Full MA Coverage**
    - Review NOCA Case Action and category
    - Approve QLE if they have proof of prior coverage within the last **120 days**

Loss of Employer-Sponsored Insurance (ESI)

- Letter from the previous employer confirming loss of coverage within the last **60 days** including:
    - Company name and contact information
    - Notice date
    - Name of employee and any member insured by ESI, if any
    - Date coverage ended (health coverage, not employment)
- Termination letter directly from prior health carrier within the last **60 days**.
- Voluntary termination of coverage does not guarantee QLE approval.

Other Types of Loss of Coverage

- **Voluntary termination** of coverage **does not** guarantee QLE approval.
- **Government Provider**
    - Proof of prior coverage that shows the expiration date within the last **60 days**.
- **COBRA**
    - Notice of termination of employer contribution to enrollment within the last **60 days**.
- **TRICARE**
    - Proof of prior coverage that shows the expiration date within the last **60 days**.
- **Department of Veterans Affairs (VA)**
    - Proof of prior coverage that shows the expiration date within the last **60 days**.
- **Peace Corps**
    - Proof of prior coverage that shows the expiration date within the last **60 days**.
- **Other State's Marketplace**
    - Proof of prior coverage that shows the expiration date within the last **60 days**.
- **Student Health Coverage**
    - Proof of prior coverage that shows the expiration date within the last **60 days**.

Sample Notices for Proof of Loss of Coverage

Samples of Notice of Case Action (NOCA)

Denial Samples:

Member submitted new MA application and was denied due to high income.

INCOME SUPPORT DIVISION
CENTRAL ASPEN SCANNING AREA
P.O. BOX 830
BERNALILLO NM 87004
PHONE NUMBER: (800) 283-4465
FAX NUMBER: (855) 804-8960

[redacted]

Case Name: [redacted]
Case Number:
Date: April 9, 2026
Revision Date: HCA 1210 March 21st, 2026

[redacted]

Notice of Case Action

Dear [redacted] Household,

This letter is about your benefits. For questions, call the Health Care Authority's Income Support Division (ISD) at **(800) 283-4465**. Or log on to YESNM at **https://yes.nm.gov/**. You have right to receive this information and help in your language at no cost. To speak with an interpreter, call 800-383-2246.

Benefit	Case Action
Medicaid	You applied on **April 09, 2026**. Medicaid is denied for all of the people who applied. To learn more, read "Your Medicaid" section below.

Based on our information, none of your household members qualify for Medicaid now. Read below why each household member was denied or closed.

Denials or Closures or Change in Benefits

Name	Month	Medicaid Type	Reason
[redacted]	April 2026	Full Coverage, MAGI Other Adults Medicaid (Category 100)	The total countable income of your assistance group exceeds program limits. (NMAC 8.296.500.11).
[redacted]	April 2026	Limited Coverage, Family Planning Medicaid (Category 029)	The total countable income of your assistance group exceeds program limits. (NMAC 8.299.500.10).

Denial: Member submitted new MA application and was denied due to immigration status.

Based on our information, none of your household members qualify for Medicaid now. Read below why each household member was denied or closed.

Denials or Closures or Change in Benefits

Name	Month	Medicaid Type	Reason
[redacted]	June 2026	Limited Coverage, Family Planning Medicaid (Category 029)	You do not have an immigration status that qualifies you to get benefits under regulation(s). (NMAC 8.200.410.11).
[redacted]	June 2026	Limited Coverage, Family Planning Medicaid (Category 029)	You do not have an immigration status that qualifies you to get benefits under regulation(s). (NMAC 8.200.410.11).

Closure Sample:

Member did not submit renewal packet for MA – Month of May was denied for full MA, therefore, benefits ended April 30, 2026.

INCOME SUPPORT DIVISION
CENTRAL ASPEN SCANNING AREA
P.O. BOX 830
BERNALILLO NM 87004
PHONE NUMBER: (800) 283-4465
FAX NUMBER: (855) 804-8960

[redacted]

Case Name: [redacted]
Case Number:
Date: April 30, 2026
Revision Date: HCA 1210 March 21st, 2026

[redacted]

Notice of Case Action

Dear [redacted] Household,

This letter is about your benefits. For questions, call the Health Care Authority's Income Support Division (ISD) at **(800) 283-4465**. Or log on to YESNM at **https://yes.nm.gov/**. You have right to receive this information and help in your language at no cost. To speak with an interpreter, call 800-383-2246.

Benefit	Case Action
Medicaid	Medicaid is closed for all members of your household. To learn more, read "Your Medicaid" section below.

Denials or Closures or Change in Benefits

Name	Month	Medicaid Type	Reason
[redacted]	May 2026	Full Coverage, MAGI Children's Medicaid (Category 401)	You did not submit your renewal packet. (NMAC 8.295.600.11).
[redacted]	May 2026	Full Coverage, MAGI Children's Medicaid (Category 401)	You did not submit your renewal packet. (NMAC 8.295.600.11).
[redacted]	May 2026	Full Coverage, MAGI Other Adults Medicaid (Category 100)	You did not submit your renewal packet. (NMAC 8.296.600.12).

Change in Benefits Samples:

Member submitted renewal and was denied due to high income – Change of full MA took place month of April, therefore, MA ended March 31, 2026, and FP started April 1, 2026.

INCOME SUPPORT DIVISION
CENTRAL ASPEN SCANNING AREA
P.O. BOX 830
BERNALILLO NM 87004
PHONE NUMBER: (800) 283-4465
FAX NUMBER: (855) 804-8960

[redacted]

Case Name:	[redacted]
Case Number:	
Date:	**March 6, 2026**

Revision Date: HCA 1210 February 7th, 2026

[redacted]

Notice of Case Action

Dear [redacted] Household,

This letter is about your benefits. For questions, call the Health Care Authority's Income Support Division (ISD) at **(800) 283-4465**. Or log on to YESNM at **https://yes.nm.gov/**. You have right to receive this information and help in your language at no cost. To speak with an interpreter, call 800-383-2246.

Benefit	Case Action
Medicaid	Medicaid is renewed but benefits changed for all members of your household. To learn more, read "Your Medicaid" section below.

Approvals

Name	Dates	Medicaid Type	Next Renewal Month
[redacted]	April 2026 - March 2027	Limited Coverage, Family Planning Medicaid (Category 029)	March 2027
[redacted]	April 2026 - March 2027	Limited Coverage, Family Planning Medicaid (Category 029)	March 2027

Denials or Closures or Change in Benefits

Name	Month	Medicaid Type	Reason
[redacted]	April 2026	Full Coverage, MAGI Other Adults Medicaid (Category 100)	The total countable income of your assistance group exceeds program limits. (NMAC 8.296.500.11). You will continue to get Medicaid under a new category. See the approval section above for more information.
[redacted]	April 2026	Full Coverage, MAGI Other Adults Medicaid (Category 100)	The total countable income of your assistance group exceeds program limits. (NMAC 8.296.500.11). You will continue to get Medicaid under a new category. See the approval section above for more information.

Change in Benefits: *Member aged out full MA category 100 – Change of full MA took place month of June, therefore, MA ended May 31, 2026.*

Denegaciones, cierres o cambios en los beneficios

Nombre	Mes	Tipo de Medicaid	Motivo
[redacted]	junio 2026	Cobertura Total, Medicaid para otros adultos de Ingreso Bruto Ajustado Modificado (MAGI) (categoría 100)	Usted ya es cubierto bajo otro programa de ayuda. (NMAC 8.296.600.11). Usted seguirá recibiendo Medicaid bajo una nueva categoría. Consulte la sección de aprobación anterior para obtener más información.

Change in Benefits: *Member submitted renewal but failed to provide proof of income – Change of full MA took place month of January, therefore, MA ended December 31, 2025.*

INCOME SUPPORT DIVISION
CENTRAL ASPEN SCANNING AREA
P.O. BOX 830
BERNALILLO NM 87004
PHONE NUMBER: (800) 283-4465
FAX NUMBER: (855) 804-8960

[redacted]

Case Name: [redacted]
Case Number:
Date: December 9, 2025
Revision Date: HCA 1210 September 14th, 2025

[redacted]

Notice of Case Action

Dear [redacted] Household,

This letter is about your benefits. For questions, call the Health Care Authority's Income Support Division (ISD) at **(800) 283-4465**. Or log on to YESNM at **https://yes.nm.gov/**. You have right to receive this information and help in your language at no cost. To speak with an interpreter, call 800-383-2246.

Benefit	Case Action
Medicaid	Your Medicaid has changed To learn more, read "Your Medicaid" section below.

Denials or Closures or Change in Benefits

Name	Month	Medicaid Type	Reason
[redacted]	January 2026	Full Coverage, MAGI Other Adults Medicaid (Category 100)	You have not provided us with the required documents we need to decide if you can get benefits. (NMAC 8.100.130).

The proofs we asked for are listed in the table below: We asked for information called proofs on the "Help Us Make a Decision" (HUMAD) letter we sent. If you need help, it is the HCA's responsibility to help you. Send the proof we asked for. We will see if you qualify. If you get benefits, they can only go back to the month you gave us the missing proofs.

NAME	VERIFICATION	EXAMPLES OF ACCEPTABLE PROOF(S) PLEASE RETURN ONE OF THE FOLLOWING):
[redacted]	Proof of income CHURCH ON THE MOVE October 22, 2025	Wage stubs or earnings statements, Employer statement, Verification of Employment Form, Contract/Work Agreement

Sample Letter for Proof of Benefits Received from Income Support Division (ISD)

CLIENT REQUEST FOR PROOF OF BENEFITS RECEIVED
SOLICITUD DEL CLIENTE PARA VERIFICACIÓN DE BENEFICIOS

INCOME SUPPORT DIVISION/DIVISIÓN DE ASISTENCIA ECONÓMICA
Revision Date: ISDB 003 January 8th, 2023

Case Number/*Numeró del Caso*	Name/*Nombre*	Individual ID/*Identificación Individual*
[redacted]	[redacted]	[redacted]

Mailing Address/*Dirección postal:* ▼

Date/*Fecha:* June 30, 2026

This is to show that [redacted] ☒ ***has*** ☐ ***has not*** received help from the State of New Mexico.
Este documento verifica que [redacted] ☒ ***recibe*** ☐ ***no recibe*** *ayuda desde el Estado de Nuevo México.*

☐ Cash Assistance in the amount of:
Asistencia en Efectivo con la cantidad de: $ 0.00

For the month(s) of:
Por los meses de:

Total months of TANF cash assistance received:
Total número de meses que recibió asistencia en efectivo TANF:

☐ SNAP benefits in the amount of:
Beneficios del Programa de Ayuda de Nutrición Suplemental con la cantidad de: $ 0.00

For the month(s) of:
Por los meses de:

☒ Medicaid for the month(s) of:
Medicaid en el(los) mes(es) de: 7/1/2024-3/31/2026

☐ No record of above.
No hay historia de registros.

COMMENTS: [redacted] had full coverage Medicaid from 7/1/2024-3/31/2026. Effective 3/31/2026 he is not
COMENTARIOS: eligible (over income) for MAGI Adult (full coverage) Medicaid.

Eligibility Worker Name/
Firma de Trabajador(a) de Elegibilidad: [redacted]

Your rights are listed on the back side of this form/*Sus derechos estan el reverso de esta forma.* ▶

Sample Disenrollment Notice from Managed Care Program (Turquoise Care)

Note: *This disenrollment notice is sent to those who were enrolled in full MA benefits but for whatever reason have lost full benefits and are being placed in Family Planning.*
This document ***is accepted*** *as proof of loss of full MA.*

TURQUOISECARE
CENTRAL ASPEN SCANNING AREA
P.O. BOX 830
BERNALILLO NM 87004

Case Number: [redacted]
Date:
Revision Date: MAD 354 June 30th, 2024

[redacted]

This letter is for:

Individual Name	[redacted]
HCA Individual ID	
Medicaid Card ID	

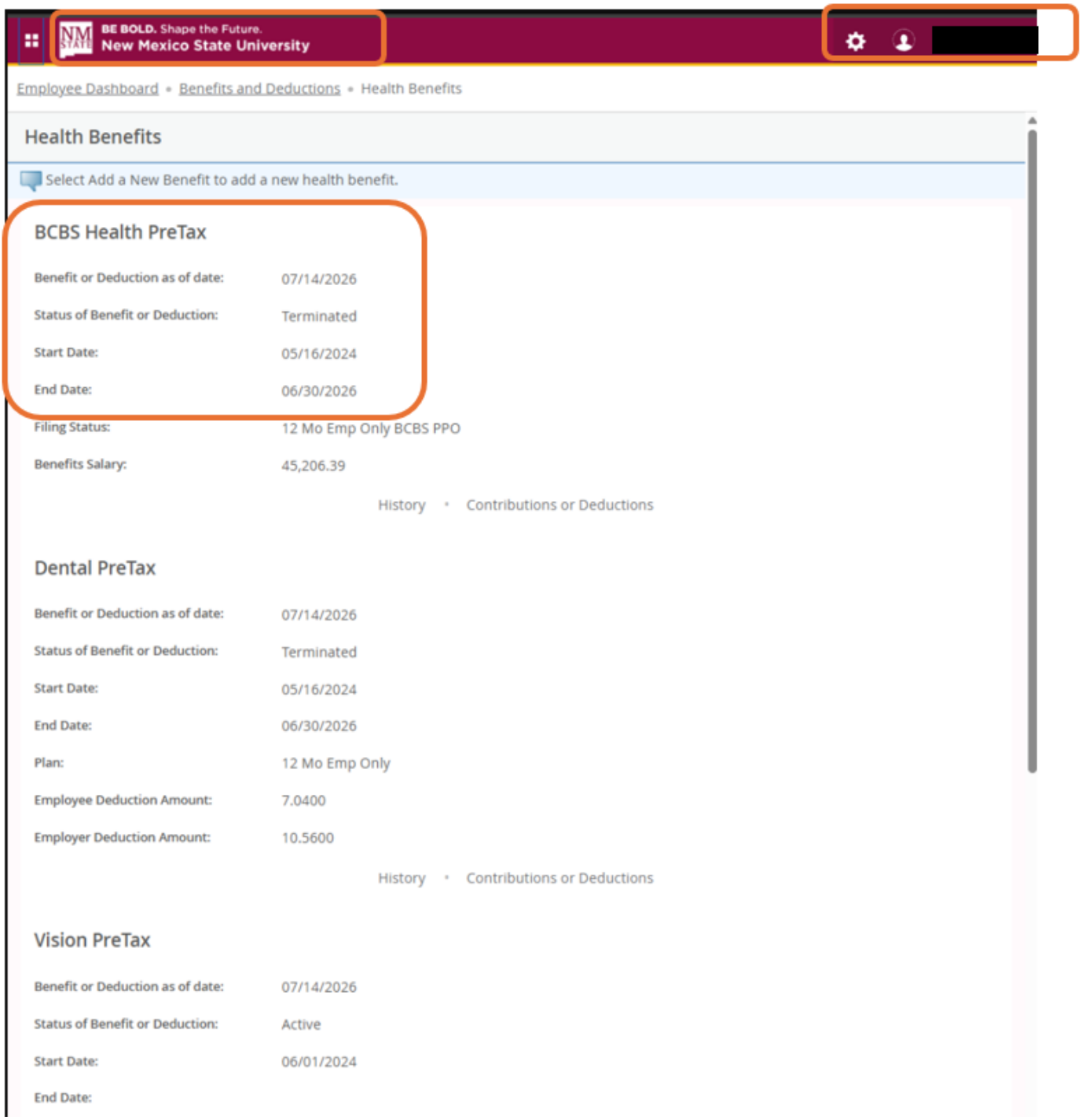
This letter is to tell you that you will no longer get your Medicaid services through the Turquoise Care program. Your Medicaid case will not close, but your Medicaid benefits may change.

Turquoise Care is New Mexico's managed care program. It uses insurance companies to give healthcare services to people who get Medicaid. These companies are called Managed Care Organizations (MCOs). Only people with certain types of Medicaid get their services from MCOs. The type of Medicaid that you get will change on **June 30, 2026.** After this date, you will not get your Medicaid services through an MCO.

If you have any questions about the type of Medicaid you will get or what services are covered, call HCA's Consolidated Customer Service Center (toll-free) at (800) 283-4465.

Sample Proof of Loss from ESI

Note: *Check for employee name, employer information, date health plan ends/ended and if other HH members were enrolled.*



DATE: July 1, 2026

TO: Whom It May Concern

FROM: Human Resources

RE: Proof of Employment through Santa Fe County

This memo is to certify that [redacted] was a Santa Fe County Employee and was covered with Santa Fe County's group health insurance. [redacted] retired from Santa Fe County effective June 26, 2026, and her last day of insurance coverage was June 30, 2026. [redacted] carried the following coverage:

Presbyterian- Employee + Family
Delta Dental- Employee + Family
Vision Service Plan- Employee + Family

Dependents covered:
[redacted]

If you have any questions or require additional information, please feel free to contact [redacted] Human Resources directly at [redacted] Thank you.

Sample Termination Letter from Carrier

BlueCross BlueShield of New Mexico
PO Box 660058
Dallas, TX 75266-0058

**********ALL FOR AADC 870
8410 1 AB 0.641 15

[redacted]

Certificate Number
****
* [redacted] *
****

CERTIFICATE OF GROUP CREDITABLE COVERAGE
BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

1. Date of this Certificate: **06/22/2026**

2. Name of health plan: **STATE OF NEW MEXICO**

3. Name of any participant to whom this Certificate applies: [redacted]

4. Name of participant/policyholder: [redacted]

5. Group-Section-Identification # of participant/policyholder: [redacted]

6. Name, address and phone number of plan administrator or issuer responsible for providing this Certificate:

   Blue Cross and Blue Shield of New Mexico
   PO Box 660058
   Dallas, TX 75266-0058
   877-994-2583

7. For further information contact your prior customer service area at: **877-994-2583**

8. If the individual identified in line 3 has at least 18 months (546 days) of creditable coverage (disregarding periods of coverage before a 95-day break), an X will appear here__ , and item 9 below will not apply.

9. Date waiting period or affiliation period (if any) began: **08/01/2025**

10. Date coverage began: **09/01/2025**

11. Date coverage ended: **06/01/2026** . If coverage is continuing as of the date of this Certificate, an X will appear here ___.

THIS CERTIFICATE REFLECTS THE INFORMATION PROVIDED TO BLUE CROSS AND BLUE SHIELD OF NEW MEXICO AS OF THE DATE OF THIS CERTIFICATE.

Statement of HIPAA Portability Rights

IMPORTANT---KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date". Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

Sample of Loss of ESI and COBRA Offer

Note: *Member does not have to enroll in COBRA after loss of ESI. But if they voluntarily disenroll before OE, they will not be granted a QLE.*

DO NOT MAIL CORRESPONDENCE OR PAYMENTS TO THIS ADDRESS

Intel
P.O. Box 770
Monroe WI 53566-0770

intel.

1033745 02 AB 0.64 **AUTO T6 0 1135 87120-173416 -C01-P33778-I

[redacted]

Notice Date: July 03, 2026

Prepared For: [redacted]

Mail check(s) and correspondence to this address only:

Intel (c/o BUSINESSOLVER.COM, INC)
PO BOX 850512
MINNEAPOLIS, MN 55485-0512

If you have any questions regarding your benefits or this notice, please login to **www.benefitsolver.com**.

COBRA Continuation Coverage & Other Health Coverage Alternatives

You're getting this notice because you recently lost coverage under Intel group health plan ("the Plan"). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Please read the information in this notice very carefully before you make your decision.

This notice has important information about your right to continue your health care coverage under the Plan, as well as other health coverage options that may be available to you including coverage through the Health Insurance Marketplace. To sign up for Marketplace coverage, visit **www.HealthCare.gov** or call 1-800-318-2596 (TTY: 1-855-889-4325). **You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** People in most states use **www.HealthCare.gov** to apply for and enroll in health coverage; if your state has its own Marketplace platform, you can find contact information here: **www.HealthCare.gov/marketplace-in-your-state/**.

Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should enroll online at **www.benefitsolver.com** or use the Election Form provided later in this notice.

Enrolling in COBRA Continuation Coverage Online Is Easy & Secure

1. **Go to www.benefitsolver.com** and log in with your username and password. If you don't know them, you may reset your username and password or **Register** as a first-time user. Your Company Key is **Intel**.
2. **Review and make your COBRA continuation coverage elections.** The online enrollment process makes it easy to select the coverage you're eligible for. Click "Start Here" to begin your enrollment.
3. **Choose the payment method you want.**
   a. **Pay Online** – Provide your bank account information. You can set up automatic monthly payments and avoid the usual $2.00 monthly convenience fee.
   b. **Pay by Check** – Make your check payable to **Businessolver**.

Deadline to Enroll in COBRA continuation coverage

Your elections must be completed and/or postmarked no later than

09/29/2026

Your active coverage ends on **07/31/2026**

If elected, COBRA continuation coverages will be effective on **08/01/2026**

If you are electing COBRA continuation coverage as a dependent electing COBRA continuation coverage, either as a result of a dependent qualifying event (such as divorce or child reaching maximum age) or the dependent of a former employee who is not also electing COBRA continuation coverage, ***you cannot enroll online.*** *You will need to return the paper election form found in this package. Once enrolled, you will be able to login to* ***www.benefitsolver.com*** *and create your online account.*

Coverage provided by Intel to you and/or your covered dependent(s) ends on 07/31/2026 due to the following qualifying event: **Employment Termination**. You have the right to elect COBRA continuation coverage for a duration of up to 18 months.

Only members covered at the time of Qualifying Event are eligible for continuation. The following Qualified Beneficiaries are eligible to continue coverage under COBRA:

[redacted]

Sample of Voluntary Termination Request Notice

Note: *Voluntary termination of coverage* ***does not*** *grant a QLE.*

PRESBYTERIAN

Presbyterian Health Plan, Inc.

Voluntary Termination Statement

(A 30-day notice is required for termination and are month-end terminations only.)

Please contact the Presbyterian Customer Service Center for help with this statement.

Phone: (505) 923-5678 or 1-800-356-2219
(TTY 711)

Email: **info@phs.org**

Hours: 7 a.m. to 6 p.m., Monday - Friday
(except holidays)

Please cancel all Presbyterian Health Plan, Inc. coverage for myself and any of my dependents who may be covered under my Six-Month Continuation of Coverage plan as of 06/30/2026.

Date

[redacted]

Name (Print)

[redacted]

Member ID

[redacted] 06/30/2026

Signature Date

Please mail this statement to:

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, New Mexico 87125-7489