



## Plan Sponsor Manual

Updated: August 2008

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# Introduction

#### INTRODUCTION

#### Thank you for choosing Blue Cross Blue Shield of Massachusetts.

We appreciate the time and effort it takes you to administer your employee benefits plan. This manual will help. Also, your Account Service Representative is available to make it easier for you and your employees to use your health or dental plan.

This manual covers eligibility, enrollment, and other important topics, with step-by-step guidelines and examples for each section. We've given special attention to questions that plan sponsors ask most often.

If you need clarification on any topic discussed in this manual, a team of Blue Cross Blue Shield of Massachusetts representatives is ready to help.

The information provided here does not constitute legal advice. This manual is for educational purposes only and is intended to assist accounts in the administration of health care plans. In no way should the contents within be considered a substitute for legal counsel, as regulations and procedures can change in accordance with the law. Consult your own attorney for individual advice.



### S E C T I O N

## Enrolling Employees in a Health Plan

- Who Is Eligible for Coverage
- When an Employee Is Eligible for Coverage
- Eligibility Conditions After a Member Is Enrolled
- How to Enroll Employees
- How to Complete the *Enrollment and Change Form*
- BlueLinks<sup>SM</sup> for Employers
- Contacts for Enrollment Questions

### Who Is Eligible for Coverage

This section does not apply to Medicare supplement plans. See Section 7, *When a Member Becomes Eligible for Medicare.* 

An employee is eligible for group coverage in an employer's group health plan when there is an identifiable employer/employee relationship, the employee earns income from the employer and claims that income according to state and federal income tax laws, and **the employee is also:** 

- A permanent full-time employee, including an owner, officer, or partner, who is regularly working 30 or more hours each week at the employer's usual place or places of business and for whom the employer pays and reports wages in accordance with state and federal wage requirements; or, if coverage also is offered to part-time employees,
- A permanent part-time employee who is regularly working at least 20 hours (but fewer than 30 hours) each week at the employer's place or places of business and is paid a wage in accordance with federal and state wage requirements.

If your company has 20 or more employees, the actively working employees and/or their spouses who are age 65 or older must be covered in a non-Medicare supplement group plan if the actively working employees (or his or her spouse) have chosen the group plan as their primary health care coverage. If the employees or spouses have chosen Medicare as the primary health care coverage, you must cancel their group coverage.

#### **Additional Eligible Members**

The following persons also may be considered as eligible group members:

- a disabled employee who is actively working or engaged in a trial work period
- a disabled employee who is not actively working but is considered an employee as part of the employer's clearly defined and consistently administered disability benefit plan
- a person defined under Massachusetts General Laws Chapter 32B, Section 2(d) as an employee of a governmental unit
- an employee who is covered under a Collective Bargaining Agreement and who is entitled to group coverage under a Health and Welfare Fund
- an owner of at least 50 percent of the business who may or may not work at the business
- a salesperson receiving commissions in the form of wages but who otherwise meets the definition of a permanent regular full-time (or part-time, if appropriate) employee and for whom eligibility is not based on the attainment of a specific amount of commissions
- prior group members who qualify for continued coverage under federal or state law
- a retired employee who qualifies under the employer's clearly defined and consistently administered retiree benefit plan

#### **Please note:**

- Employees selecting a managed care plan must reside in the plan's enrollment area. (See p. 2-5.)
- For more information on active and retired employees age 65 or older, please see Section 7, *When a Member Becomes Eligible for Medicare*.

This section does not apply to Medicare supplement plans. See Section 7, *When a Member Becomes Eligible for Medicare*.

#### **Initial Enrollment Policy**

A member's initial eligibility is a qualifying event for the purposes of determining the member's effective date of coverage with the employer's group health plan.

An eligible employee may enroll in the employer's group plan as an individual or family (if applicable) as of the:

- date of hire or date of completion of the employer's probationary period
- date the employee's permanent regular work hours meet the definition of an eligible employee (20 to 30 hours if part-time and at least 30 hours if full-time)
- date the employee involuntarily lost coverage under a spouse's group plan
- date the employee involuntarily lost coverage under a non-group plan
- date the employee voluntarily canceled coverage under another health plan due to the total termination of an employer's contribution
- date the employee acquired a new dependent due to marriage, birth, or adoption (adoption is subject to underwriting approval)
- date the employee is required to provide health insurance for a dependent under a Child Support Court Order (child must be enrolled with the employee)

When an eligible member who declined enrollment in the employer's plan due to enrollment in another group plan involuntarily loses that coverage or voluntarily cancels it on the date the employer ceased all contribution (or the employee or other dependent exhausts COBRA coverage under another group plan), he/she may enroll as of the date the other coverage was canceled. Documentation in the form of a Certificate of Creditable Coverage must include the name of the prior employer and insurance carrier, the member's identification number, enrollment and termination dates, the termination reason, and the names of all members covered under the plan. Documentation is not required if the prior coverage was involuntarily lost and was offered or administered by Blue Cross Blue Shield of Massachusetts.

When an Employee

**Coverage (Employee** 

**Qualifying Events)** 

**Is Eligible for** 

#### Internal Revenue Code—Section 125 Trust Plans

Some employers have established a Section 125 Trust Plan (cafeteria plan) with the IRS that stipulates when members may be added, removed, or transferred within the employer's group health plan.

The IRS allows the employer to select specific qualifying events from a predetermined list of events. These include all of the Blue Cross Blue Shield of Massachusetts qualifying events as well as one not considered as a qualifying event by us: a significant increase in cost or significant decrease in coverage under the member's current health plan.

If we receive an enrollment request that does not comply with our eligibility policy but does comply with the employer's Section 125 Trust Plan, the request can be approved with documentation of the employer's qualifying events as filed with the IRS.

#### **Ineligible Persons**

The following persons may not be considered as eligible group members and therefore may not enroll in the employer's group health plan:

- a person who works for the employer sporadically or as needed or at will or on a seasonal basis or who does not meet the definition of a permanent regular employee
- a former employee who no longer meets the definition of a permanent regular employee and who does not qualify as eligible as a disabled employee, or as a retired employee, or as a former employee entitled to continued coverage under federal or state law
- corporate directors or trustees who do not meet the definition of a permanent regular employee
- friends, relatives, business associates, or any other persons who do not meet the definition of a permanent regular employee
- contractors, attorneys, consultants, accountants, and other associates who may or may not be paid for periodic services by the employer and/or who do not meet the definition of a permanent regular employee
- any dependent of any of the above person(s)
- any person who is not considered an eligible dependent of an eligible enrolled member
- any otherwise eligible dependent of a member who is eligible but not enrolled
- any person not specified as an eligible member in the plan description and rider(s) that describe the employer's health care plan

This is an example of how to complete the *Enrollment and Change Form*.

Blue Cross Blue Shield	ACHUSETTS of Massachusetts is an Indepen os and Blue Shield Association	Be	case Read The fore Filling Out case PRINT CLEAR r black ink to avoid c	This Form.			nent and Change Form 2.0. Box 9145, North Quincy, MA 02171-9145
	lled Out by Your				Gummer	Andiana Comment	Medical Group # Transferring To
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Current BCBS II 9999 Type of Transa	999999	Requested Effect	2007	MM DD	2006	Current Dental Group #	Dental Group # Transferring To
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are you selecting?	Blue Choice	РРО	Other (Write )			Individual Family	Individual Family
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Street Address	P.O. Box #		Apt. #		PLE	State , Zip	MM DD YYYY
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Are you Covered by Medicare?							Actively Working Y/N
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							MM DD YYYY
Street Address / H	P.O. Box #		Apt. #	City/Town			Code
Social Security	y#	Telephone # (area code) ( )		ther Insurance? •	Other Hea	th Insurance Company Name	City/State
PCP ID #: (se	e instructions)		Name of PCP	A	City	/State	Is this your current PCP? Mark X, if yes.
Is Member 2 Covered	Part A Effective Dat	e Part B I	Effective Date	Part D Effec	tive Date	Medicare #:	Actively Working Y/N
by Medicare? • Y /N	MM DD	איזיז או			DD YYYY		ESRD If Retired, Date:
4 Tell Us A	• If y bout Your Depe			our Medicare or othe	r insurance status, y	ou may receive a follow-up quest	ionnaire.
Dependent's Fin		idents (Membe		Last Name			Sex Full-time student? Age 19 or over
3.) Social Security	*	Date of Birth	PCP	D Number (see inst	ructions)	Name of PCP	Is this your current PCP?
Dependent's Fin				Last Name		Traine of Fea	Mark X, if yes.
4.)							Sex Full-time student? Age 19 or over Y / N
Social Security	*	Date of Birth	PCP	D Number (see inst	ructions)	Name of PCP	Is this your current PCP? Mark X, if yes.
Dependent's Fin	st Name		M.L	Last Name			Sex Full-time student? Age 19 or over
Social Security	*	Date of Birth	PCP II	D Number (see inst	ructions)	Name of PCP	Is this your current PCP?
Please check if w	ou are using separate for	me for additional dense		100 A	active inter	Total # of Dense dents:	Mark X, if yes.
	rsonal Savings Ac	And the second second		213 5.10.1		Total # of Dependents:	
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FSA - De	p. Start Date s (Employer & B	and the second second	d Date	De	pendent Care \$:		and the Alexandre
	·		stand that Blue C	ross and Blue Sl	hield will rely or	this information to enroll	me and my dependents or to make
changes to my	membership. I un	derstand that I sho	uld read the subs	criber certificate	or benefit bool	det provided by my emplo	over to understand my benefits and al information about me to carry out
its business, a	nd that it may use a	nd disclose that inf	ormation in accor	dance with law.	I acknowledge	that I may obtain further i	information about the collection, use
and disclosure	of my information	n "Our Commitme	ent to Confidentia	ality," Blue Cross	s and Blue Shie	d's notice of privacy practi	ices.
Employee's Sign	wel S	unple	11/2/00	e	Frank Employer's Signatu	Falle	11/3/06
-			1.12			1	363630 3/07

Request for New Member Waiver Form

#### How to Enroll Employees

To enroll employees in a health plan, when a group account cannot send us an enrollment request via electronic processes such as FileLink<sup>®</sup> or BlueLinks<sup>SM</sup>, we still require the request in writing. We require that the request be sent to us in writing from the account when an enrollment request is not through FileLink or BlueLinks. For security and confidentiality reasons, we prefer that the enrollment requests be sent to us by mail (i.e. US mail or other private delivery of hard copy documents) or by fax. However, we will accept written enrollment requests via e-mail if the group account chooses this option.

**Please note:** We encourage you to submit enrollment requests as early as possible. We must receive a notice of a new enrollment to your plan within 60 days of the qualifying event.

If you do not enroll your new employee within 60 days of the requested effective date, the employee is not eligible to enroll until your next open enrollment period.

Do not enclose enrollment requests with your monthly bill. The processing delay could affect employees' coverage.

For employees enrolling in an HMO or POS product (including Medicare HMO Blue<sup>®</sup>):

• Each member must permanently reside in the designated enrollment area in order to be eligible for plan coverage. Also, except for student dependents, all dependents must reside within the service area (or live and/or work within a reasonable distance from the service area).

**Additions:** Requests to add members to the employer's plan must be effective as of the member's qualifying event or as of the employer's open enrollment date and must be received by us within 60 days of the requested effective date. The addition requests must be signed and dated by the employer and the employee.

**Removals:** Requests to remove members from the employer's plan can be effective at any time if we receive the request within 60 days of the requested effective date. The removal requests must be signed and dated by the employer and, except for "left employ" removals, should be signed and dated by the employee.

**Transfers:** Requests to transfer members from group to group within the employer's plan must be effective as of the member's initial eligibility date for the group transfer or as of the employer's open enrollment date and must be received by us within 60 days of the requested effective date. The transfer requests must be signed and dated by the employer and the employee.

Eligible members may transfer from the employer's managed care plan to another plan of the employer within 60 days of moving outside of the plan's enrollment area or as of the date the employer no longer offers the managed care plan as a benefit option.

Eligible members may transfer from another plan of the employer to the employer's managed care plan within 60 days of moving into the plan's enrollment area or as of the date the employer no longer offers the member's current plan as a benefit option.

**Reinstatements:** Eligible members who were terminated in error by the employer or who were terminated for non-payment of premium may be reinstated as of their termination date when:

- the period of reinstatement is four months or less; and
- the correct termination reason was other than voluntary or transferred to another group plan; and
- the member has not been reinstated more than once within the past three years.

Please put your requests in writing to your Account Service Consultant.

#### **Exception Enrollment Procedures**

Requests for exceptions to our standard eligibility or enrollment policies and procedures are sent to our Member Underwriting Department for review. These requests must include all available documentation and facts to support a decision.

How to Complete the Enrollment and Change Form

All employees who wish to join a health plan—even those who may have been members in the past—would complete in full the *Enrollment and Change Form*.

After your employees have completed this form, they must return it to you. Please make sure:

- The application is legible.
- All the appropriate spaces are filled in. (See the following example for an explanation.)
- The application is signed by the employee and the employer.
- Mail applications to:

Enrollment Department Blue Cross Blue Shield of Massachusetts P.O. Box 9145 North Quincy, MA 02171-9145

See the attachment to the *Enrollment and Change Form* for more details on how to fill out and submit the form.

This is a sample of the *Enrollment and Change Form*.

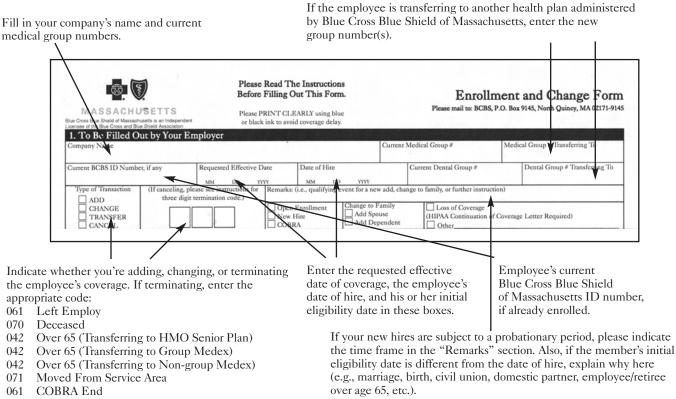
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ensee of the Blue Cross and Blue Shield Association . To Bc Filled Out by Your Em		ink to avoid coverage delay.	-		
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TRANSFER O	42	Open Enrollment New Hire COBRA	Change to Family Add Spouse Add Dependent	Loss of Coverage (HIPAA Continuation of C	overage Letter Required)
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oducts Network Blue	Access Blue	Blue Choice New England Other (Write Name of Plan)		(Medical) Individual Family	(Dental) Individual Family
ur First Name		M.I. Last Name	NPLE		Sex Date of Birth M 04 22 1970
reque Address /P.O. Box #		Apt. # City Town	tin	State Zip C	Add 7715
Social Security #	tr555-0(	00 Other Insurance	?• Other He	alth Insurance Company Name	City/State
PCP ID #: (see instructions)		e of PCP	Cit	y/State	Is this your current PCP? Mark X, if yes.
e you Covered Part A Effective Date Medicare?	Part B Effective	e Date Part D	Effective Date	Medicare #:	Actively Working Y/N
		DD YYYY MA			ESRD If Retired, Date:
Tell Us About (Member 2) mber 2's First Name	Please check or	M.I. Last Name		Partner Dive	Sex Date of Birth
eet Address / P.O. Box #		Apt. # City/Town		State Zip C	
Social Security # Telep	hone # (area code)	Other Insurance Y/N	• Other He	alth Insurance Company Name	City/State
PCP ID #: (see instructions)	Name	e of PCP	Cit	y/State	Is this your current PCP? Mark X, if yes.
Member 2 Part A Effective Date wered	Part B Effective	e Date Part D	Effective Date	Medicare #:	Actively Working Y/N
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. Tell Us About Your Depender			'older fitsterande staties,	уов тау писте а јонош-вр двезна	*******
ependent's First Name		M.I. Last Name	instructions)	Name of PCP	Sex Full-time student? Age 19 or over Y / N Is this your current PCP?
ependent's First Name	or birdi	M.I. Last Name	, macucciona,	Name of PCP	Mark X, if yes.
	of Birth	PCP ID Number (see	instructions)	Name of PCP	Age 19 or over Y / N Is this your current PCP?
ependent's First Name	1 1 1 1	M.I. Last Name			Mark X, if yes. Sex Full-time student? Age 19 or over
Social Security # Date of	of Birth	PCP ID Number (see	instructions)	Name of PCP	Is this your current PCP? Mark X, if yes.
ease check if you are using separate forms for	additional dependent ch	hildren.	Maria	Total # of Dependents:	
Select Personal Savings Accou	nt (if applicable)				
HSA Start Date	End Date End Date		FSA ( Health \$:	GOAL AMOUNTS: (Please see in	structions for maximum limits
FSA - Dep. Start Date	End Date		Dependent Care \$:	Station State	
Signatures (Employer & Emp he information here is complete and anges to my membership. 1 underst by restrictions that apply to my health is business, and that it may use and di	true. I understand t and that I should rea a care plan. I underst sclose that informati	ad the subscriber certificand that Blue Cross and in accordance with	e Shield will rely o cate or benefit boo d Blue Shield may law. I acknowledge	oklet provided by my employ obtain personal and medica e that I may obtain further in	yer to understand my benefits and l information about me to carry ou formation about the collection, u
nd disclosure of my information in "O	ur Commitment to C	Jonnigentiality, blue (			

The *Enrollment and Change Form* may be used to add, change, or terminate an employee's coverage. For fast and accurate enrollment processing, please use black or blue ink, and write letters and digits as shown:



This is an example and explanation of how to complete the Enrollment and Change Form.

The *employer* should fill in section 1:



041 Voluntary (Other than above)–Employee signature required

(See Section 5 of this manual for further information about changing or terminating an employee's coverage.)

The employee should complete the following:

#### Tell Us About Yourself (Member 1)

The employee fills in his or her name, address, sex, date of birth, social security number, and phone number, as well as the provider number for the primary care physician (PCP) (managed care plans, **HMO and POS** only).\* The PCP's provider number is listed in the provider directory of the chosen health plan. What Product Are You Selecting? The employee indicates the coverage desired. If the plan selected is not shown, the employee checks "Other" and writes in the plan name.

#### Kind of Membership

1

The employee should indicate whether he or she is joining as an individual, as a family, or other.

2. I CII US AD	out Yourself (N	(lember 1)	Section States			/						
What products are you selecting?	HMO Blue Network Blue Blue Choice Saver Product	Dental Blu Access Blu PPO	e 🗌 Bla	MO Blue No ue Choice N her (Write Na	lew England			Kind of M (Medical)		6	Kind of Meml Dental) Individual Family	
our First Name					ast Name					Sex	Date of Birth	11111
Street Address / P.O	). Box #		A	Apt. #	City/Town			State	Zip Code			
Social Security #	ŧ	Telephone # (area ()		Y/	ner Insurance? •		alth Insurance C	ompany Na	ime		City/Stat	
PCP ID #: (see i	instructions)		Name o	f PCP		City	y/State	<i>r</i>			is your current k X, if yes.	PCP?
Are you Covered by Medicare? *	Part A Effective Da	ite Pa	art B Effective I	Date	Part D Effectiv	e Date	Medicare #:	-		Y/1		
Y/N	MM DD	YYYY	MM DD	11111		DD זיזיז	65-	Disable	ed ES	RD If R	etired, Date:	_
	out (Member 2	2) Please	e check one			Domestic	Partner				se (court o	
Member 2's First N	lame		1.1	M.I. La	ast Name					Sex	Date of Birth	11111
Street Address / P.C	). Box #			pt. #	City/Town		1	State	Zap Code			
Social Security #	*	Telephone # (area	code)	Oth	her Insurance? •	Other Hea	alth Insurance C	ompany Na	ime		City/Stat	e
PCP ID #: (see i	instructions)		Name o	f PCP		City	yState			Mar	is your current k X, if yes.	
Is Member 2 Covered by Medicare? *	Part A Effective Da	ate Pa	art B Effective I	Date	Part D Effectiv	re Date	Medicare #:			Y/		
ov medicare?	MM DD	mm	MM DD	2002	MM	DD YYY	45.	Disable	d Des	RD If F	etired, Date:	

If the employee selects family or other coverage, he or she enters the spouse's information here. If the employee or the employee's spouse has other health insurance coverage, he or she should fill in the insurer's name, city, and state.

If the employee and/or spouse is covered by Medicare, he or she should enter a "y" and fill in the Medicare number.

\*If the employee, spouse, or dependents are enrolled in a managed care plan, and no PCP number is given, benefits cannot be guaranteed.

The *employee* should also complete the following:

#### Tell Us About Your Dependents

If the employee chooses family or other coverage, this section should be filled out completely for each child or other eligible dependent to be covered. A second *Enrollment and Change Form* may be attached if necessary.

The employee indicates whether the
dependents are full-time students.
· \

3.) Social Security #	Date of Birth	PCP ID Number (	ee instructions)		Name of PCP		Fall-time studen Age 19 or over Y Is this your current I Mark X, if yes.
Dependent's First Name		M.I. Last Name				Sex	Full-time studen Age 19 or over
Social Security #	Date of Birth	PCP ID Number (	see instructions)	>	Name of PCP		Is this your current Mark X, if yes.
Dependent's First Name		M.I. Last Name		11		Sex	Full-time studen Age 19 or over Y
Social Security #	Date of Birth	PCP ID Number (	see instructions)		Name of PCP		Is this your current Mark X, if yes.
Please check if you are using separat	te forms for additional dependent chil	dren.		Tota	I # of Dependents:		All and a second
5. Select Personal Saving	s Account (if applicable)						
HSA Start Date		and the second second		FSA GOAL	AMOUNTS: (Please see instr	ructions for ma	ximum limits
FSA - Health Start Date	End Date		Health \$:				
FSA - Dep. Start Date	End Date		Dependent	Care \$:			Second Second
6. Signatures (Employer	& Employee)						
changes to my membership. any restrictions that apply to p its business, and that it may u	plete and true. I understand the I understand that I should read my health care plan. I understa use and disclose that informatio tion in "Our Commitment to Co	the subscriber cern nd that Blue Cross n in accordance wit	and Blue Shie th law. I ackno	fit booklet p d may obtain wledge that	n personal and medical i I may obtain further info	nformation abo	and my benefits about me to car
A PERSONAL PROPERTY AND A PROPERTY A	-	2 M AND	Produce	's Signature	And the second se	Da	te
Employee's Signature		Date	Employe	o orginatore	and the second of the second		363

Please note: This paragraph tells you why Blue Cross Blue Shield of Massachusetts requires signatures.

**Please note:** We need birth dates of the subscriber, spouse, and eligible dependents to issue identification cards. Both the employee and the employer must sign and date the application.

#### Incomplete and unsigned applications cannot be processed.

The following example shows how to add a subscriber or employee to your plan.

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	ssachusetts is an Independ nd Blue Shield Association			oid coverage delay				1.1	1.1.1		
	l Out by Your l	Employer				0	1.5.16		Madias	Const Treef	in Th
mpany Name	BCC	ompany	1			O	Medical Group	101	Medical	Group # Transfe	rnng Io
rrent BCBS ID Nu	umber, if any	Requested Effectiv	2007	Date of Hire	200		Current Dent			Dental Group # 7	Transferring T
Type of Transaction		please see instructions f it termination code.)	for Remarks	s: (i.e., qualifying o	event for a new	v add, cha	nge to family, o	r further instruct	ion)		
CHANGE TRANSFER CANCEL				n Enrollment v Hire BRA	Change to F Add Spo	usc			Coverage I	Letter Required)	1. 1. 1.
	ut Yourself (M									W-1-614	
ducts	HMO Blue Network Blue	Dental Blue		lue New England toice New England				Kind of Mem (Medical)	1.1	Kind of M (Dental)	
octing?	Blue Choice	Access Blue	Other (V	Write Name of Plan)				Individual		Individ	
ar First Name	Saver Product		M	I.I. Last Name				<u> </u>	Sea		irth
SAM	UEL	I I I		SSAN	MPL	IE		1.1	1 1	N 04 2	2 1970
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#### Medicare Secondary Payer Compliance Project

Federal regulations require us to determine if any of our members are also covered under Medicare. Whenever a new member is added or an employee changes groups or employers, this form is sent to determine Medicare coverage status.

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**FileLink®** FileLink is the account-batch maintenance facility that features a full-file or activity-only update capability. We will systematically take in data from your payroll/HR system, compare it to our enrollment eligibility database, and make the appropriate changes.

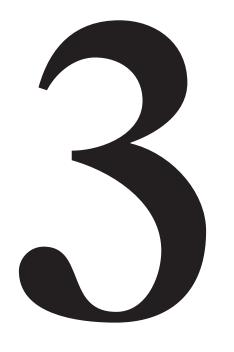
#### BlueLinks for Employers

BlueLinks for Employers is an online resource that enhances employers' business relationship and operations with Blue Cross Blue Shield of Massachusetts. BlueLinks enables employers to conduct health plan maintenance and real-time\* transactions in a secure and convenient online setting.

BlueLinks for Employers includes a comprehensive collection of additional resources to assist you in health plan management and responding to the needs of your employees. These resources include:

- Forms Library: This library includes downloadable forms (in Adobe Acrobat PDF format) to help you do your business with Blue Cross Blue Shield of Massachusetts, such as Fitness Benefit and member application forms.
- Employee Education: This section contains health care-related educational opportunities for you and your employees, such as WebMD<sup>®</sup> University, the value of generic medications, our online hospital quality comparison tool, etc.
- Health and Wellness: This resource contains information about all of the offerings within our Health and Wellness program, such as our Healthy Blue discounts.
- Care and Disease Management: This section includes information on Blue Cross Blue Shield of Massachusetts' various disease and care management programs, from our e-Blue Health resources for health-transitional members to our Blue Care<sup>®</sup> Connection programs for our members who can benefit from disease management.
- \* Please note that transactions will be processed in real time from 7:00 a.m. to 8:00 p.m., Monday through Friday, and transactions completed at other times will be processed as of 7:00 a.m. the following business day.

	In order to register, you must determine who will be the primary contact representing the account—this person will be identified as the "super user." Although the super user will be able to register online, they will need to obtain a PIN number, which can only be provided by their assigned Blue Cross Blue Shield of Massachusetts sales or service representative. This helps guarantee the authenticity and validity of the super user.
	Once the super user completes the registration online, they will be provided with a user name and password, which is necessary to log in to the secure site. BlueLinks for Employers is located on our corporate website at www.bluecrossma.com/foremployers.
	BlueLinks for Employers does not affect your use of the FileLink system. You should still continue to use FileLink for your health plan maintenance. However, you can use the BlueLinks system to make immediate updates with the Enrollment Management tool in conjunction with your regular FileLink maintenance. It is important to note, however, that failure to update this data within your employer's HRIS system will cause the next file transfer to overwrite any updates you made in Enrollment Management.
	If you'd like to use the BlueLinks for Employers system, you should speak with your account service representative to begin the process.
Questions?	If you are using the Enrollment Management tool, or FileLink, please call the BlueLinks Help Desk at <b>1-800-650-9808</b> . All others should call the Enrollment Help Desk at <b>1-617-246-9966</b> .
	These programs are available to accounts of a certain size. Please contact your Account Service Representative for more information about these products.



### S E C T I O N

## Enrolling Dependents in a Health Plan

- Who Is Eligible for Coverage
- Health Care Reform and Frequently Asked Questions
- How to Enroll Dependents
- How to Complete the *Enrollment and Change Form*
- Student and Dependent Eligibility Report
- Type of Contract Adjustment Report
- Enrollment Underwriting

If an employee requests family coverage, existing eligible dependents are enrolled at the same time as the employee. This section expands the definition of dependents and provides special instructions regarding dependent coverage.

#### Who Is Eligible for Coverage

#### **Eligible Dependents**

If the employer offers family coverage to eligible employees, the following dependents may enroll:

- legal spouse—a spouse is an individual who is considered under applicable state law to be legally married to an employee. This includes a same sex spouse and common law spouse whose marriage is recognized as a legal marriage under the laws of the state in which the couple resides
- partner of a civil union if you have determined that such civil union partner is eligible for enrollment
- dependent age 25 or under
- unmarried dependent student
- dependent legally adopted\*
- dependent legal ward under guardianship\*
- dependent under a Child Support Court Order\*
- disabled dependent child\*
- child of a covered unmarried dependent
- domestic partner is by rider

#### **Former Spouse**

In the event of divorce or legal separation, the employee's former spouse may maintain coverage under the employee's membership only until: the employee is no longer required by the divorce judgment to provide health insurance for the former spouse; or the employee or former spouse remarries. Speak with your account executive for more information.

#### **Dependent Qualifying Events**

An eligible dependent may enroll as part of the employee's contract as of the:

- new spouse's date of marriage to the employee
- date of civil union
- child's date of birth, adoption, or legal guardianship\*
- date of birth of child of a covered unmarried dependent
- date specified in a Child Support Court Order\*
- date the spouse and/or child involuntarily lost coverage under another health plan\*
- date the spouse and/or child voluntarily canceled coverage under another health plan due to the termination of an employer's contribution\*
- date domestic partners sign an affidavit attesting to their relationship

Please be sure to review what is needed to add dependents on page 3-15.

\*Additional documentation is required along with the enrollment application.

#### **Open Enrollment Eligibility Policy**

Eligible employees and their eligible dependents who did not enroll as of their initial eligibility date may enroll in the employer's group plan as of the employer's open enrollment effective date.

#### **Newborn Dependent Children**

Coverage for a newborn natural child becomes effective on the child's date of birth provided the male or female subscriber arranges for a family contract by completing an employer's enrollment transaction request in writing not more than 60 days after birth. If the enrollment is not received within the time period allowed, we will require an official Record of Birth, as recorded with the applicable state agency (hospital birth records are **not** acceptable documentation).

When the mother of the newborn is either the subscriber or dependent child enrolled on the policy, additional supporting documentation is not required provided that the mother's maternity claim for the birth is recorded on the Blue Cross Blue Shield of Massachusetts claims system.

When the father of the newborn is not named on the birth record, we will accept results of laboratory paternity testing, or a letter from his attorney naming the father, or a court issued Judgment of Paternity, or court order naming the subscriber as the father of the child.

#### **Children of Unmarried Dependent Children**

Coverage is available for the children of a dependent child who is enrolled under the subscriber's family contract. Additionally, for managed care plans, the child of the dependent must reside in the plan's service area. See the plan description for a description of the service area. Coverage for the dependent's child will become effective on the child's date of birth, by completing an employer's enrollment transaction request in writing not more than 60 days after the child's date of birth. Additional supporting documentation is not required provided the mother's maternity claim is recorded on the Blue Cross Blue Shield of Massachusetts claims system, otherwise, we require an official Record of Birth (hospital birth records are **not** acceptable documentation).

#### **Adopted Dependent Children**

A subscriber must enroll legally adopted dependent children under a family contract in order to ensure coverage for the dependent child.

A subscriber who is enrolled under an individual contract must arrange for a family contract by completing the employer's enrollment transaction request in writing not more than 60 days after the adoption (or placement in the home for the purpose of adoption or the petition to adopt if the child has been residing in the home of the subscriber as a foster child).

A subscriber who has a family contract must notify us to add a new dependent to the family contract by completing the *Enrollment and Change Form* not more than 60 days after the adoption (or placement in the home for the purpose of adoption or the petition to adopt if the child has been residing in the home of the subscriber as a foster child).

Important: To ensure corporate compliance with the eligibility requirements, all foreign and U.S. adoption requests may not be added without written approval of the Blue Cross Blue Shield of Massachusetts Member Underwriting Department.

#### **US Adoptions**

Children age 26 or under who are legally adopted or placed in the home for the purpose of adoption are eligible for coverage under the employee's contract as of the date of adoption. A signed attestation from the licensed adoption agency that identifies the child and verifies the date and basis of placement or documents from state agencies, or court documents are required.

The effective date of coverage for an adopted child who has not been previously residing with the subscriber will be the date of placement (for the purpose of adoption) in the subscriber's home, by a signed attestation from the licensed adoption agency.

The effective date of coverage for an adopted child who has been residing with the subscriber and for whom the subscriber has been receiving foster care payments will be the date the petition to adopt is filed.

#### **Foreign Adoptions**

For foreign adoption, if the date of placement with the adopting parent(s) is not noted in the adoption documentation from the official government papers translated into English, a copy of the child's picture passport and a page showing a Department of Homeland Security, US Customs and Border Protection date stamp are required. Or, Blue Cross Blue Shield of Massachusetts requires a letter from a United States licensed adoption agency stating the "date of placement for the purpose of adoption." Please contact your Account Service Representative for instructions on additional required documents.

#### **Disabled Dependent Children**

The subscriber must make special arrangements for the disabled child to continue coverage under the family contract. Not more than 30 days after the date the child would normally lose eligibility, the subscriber must complete the *Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form* and supply us with any medical or other information that we may need to determine if the child is eligible to continue coverage under the subscriber's family contract. We will make the final determination of the child's eligibility for continued coverage. (See instructions on the form.) We may conduct periodic reviews to verify the child's continued eligibility as a disabled dependent; these reviews will require a statement from the child's physician.

This is a sample of the *Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form.* 

MASS	SACHUSETTS	Blue Cross Blue Shield of Massachusetts Member Underwriting Mail Stop 01-07 Landmark Center 401 Park Drive Boston, MA 02215-3326	Request for Retaining Coverage for a Psychologica or Physically Disabled Dependent Ch
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#### Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form (Front)

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Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form (Back)

Disabled dependents are allowed by state law to continue coverage under the parent's health insurance if certain eligibility and medical criteria are met. Review and approval/denial/certification/recertification of coverage for disabled dependents are the responsibility of the Blue Cross Blue Shield of Massachusetts Member Underwriting Department. To ensure corporate compliance with state law, disabled dependents may not be added to or removed from any membership without the written approval of the Blue Cross Blue Shield of Massachusetts Member Underwriting Department.

The review process involves a determination of the child's eligibility based on the onset of the condition as it relates to the parent's contract limitations for dependent coverage and a review of medical records to determine the child's capability for engaging in self-supporting employment.

If the child is considered an eligible disabled dependent, a determination is made to continue coverage on a permanent (for the duration of the condition and/or the parent's contract) or a temporary basis. Temporary disabled dependent status is recertified on an annual basis.

Make sure the subscriber submits a *Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form.* 

#### **Domestic Partners and Their Dependents**

Coverage for domestic partners and their dependents is available as a rider to qualified accounts. Contact your Account Executive for information and eligibility requirements for this option.

#### **Older Dependent Children**

Requests to add dependent children to an existing family contract when the child's date of birth or initial eligibility is prior to the effective date of the existing contract require Underwriting approval to confirm eligibility, where applicable, and proof of paternity/maternity.

#### **Student Dependent Children**

Most group contracts cover student dependents. Please refer to your benefit literature to determine whether student dependents are covered under the contract and until what age that coverage is available. If your company has chosen to offer student dependent coverage (and most companies do because it's a standard benefit), the following applies:

• Unmarried full-time student children who live with the subscriber or spouse on a regular basis may continue coverage under the employee's family contract. The subscriber must give the plan verification that the child is a full-time student and remains full-time at an accredited educational institution. Coverage ends when the student turns age 25 (age requirement may vary by employer group) or marries, or on November 1 after the date the student discontinues full-time classes or graduates, whichever comes first.

- An accredited educational institution is defined as an institution certified by an appropriate accrediting agency (located in the state that the school, college, or university resides in). Eligible students include:\*
  - High school students
  - Undergraduate students attending college with 12 or more credit hours per semester
  - Graduate students attending college with 12 or more credit hours per semester

If you have any questions, please feel free to contact your Account Service Representative.

\*Please note that these requirements may vary, and that the school ultimately determines full-time status.

#### **Court-Ordered Child Support**

Child Support Court Order law requires that any employee's child under a health care support order be covered under the employer's group health plan, by completing the employer's Enrollment and Change Form and providing a copy of the court order.

Once enrolled, the child's coverage must be continued until the support order is no longer in effect, or until the child is enrolled under another comparable health plan, or until the employee is no longer eligible for the employer's group plan, or until the child reaches the plan's maximum age limit or marries, whichever comes first.

- At the account's request, if the employee is not enrolled already in the employer's health plan, we will allow the employee and child to enroll as of the date of notification. However, this is not a qualifying event allowing the employee to enroll under individual coverage. The employee will be allowed to enroll only if the child also is enrolled.
- If the employee is enrolled in the employer's managed care health plan and the child does not live within a reasonable distance from the service area, the child must be allowed to enroll in the plan. This situation does not create a qualifying event for the employee to transfer to another product or coverage. The employee may enroll in another health plan of the employer as of the next open enrollment.

#### **Divorce or Legal Separation**

**Divorce:** A former spouse may continue coverage under the employee's family contract until the former spouse or the employee remarries unless the the divorce document specifies otherwise. When the employee remarries, the former spouse may be enrolled under an individual contract if the divorce document specifies that the employee must continue coverage for the former spouse.

**NOTE:** When the employee or the former spouse remarries and the divorce document requires continued coverage for the former spouse, the former spouse may not continue coverage under the employee's family contract even if the employee's new spouse does not wish to be covered under the employee's group plan.

**Separation:** A spouse may continue coverage under the employee's family contract until a divorce occurs unless the separation agreement specifies otherwise.

#### Health Care Reform Updates on Dependent Eligibility—Effective January 1, 2007

As a result of the passage of the health care reform bill in Massachusetts (Chapter 58 of the Acts of 2006), changes have been made to the eligibility provisions for our insured plans. Beginning on January 1, 2007, the following will define our standard eligibility for dependent coverage.

#### **Changes to Standard Eligibility Provisions for Dependents**

Coverage for dependents, including adoptive children and newborns, has been extended to age 26, or for two calendar years after the dependent last qualified as a dependent under the Internal Revenue Code, whichever comes first. The two-year extension of eligibility period begins on January 1 of the calendar year in which the dependent is no longer being claimed on the subscriber's or spouse's federal tax return.

#### **Additional Dependents to Be Covered**

In addition to the new guidelines, we also cover the following dependents:

- Legal spouse.
- Children who are recognized under a Qualified Medical Child Support Order as having the right to enroll for coverage under the plan.
- Unmarried full-time students who otherwise do not qualify but meet all of the following criteria:
  - Up to age 25,
  - Enrolled as a full-time student at an accredited educational institution, and
  - Who live with the subscriber or the spouse on a regular basis.

#### Health Care Reform

- Disabled dependent children. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled under the subscriber's membership, will continue to be covered after he or she would otherwise lose dependent eligibility, so long as the child continues to be mentally or physically incapable of earning his or her own living.
- A newborn infant of an enrolled dependent from the moment of birth and continuing until the enrolled dependent is no longer eligible as a dependent.

#### Frequently Asked Questions about Dependents under Health Care Reform

#### Q: Will all dependents be covered up to the age of 26?

No. Under the law, family memberships must provide dependent eligibility coverage up to age 26, or for two years after the dependent last qualified as a dependent under the Internal Revenue Code, whichever comes first.

#### Q: When does a dependent's two-year extension of eligibility period begin?

The extension of eligibility period will begin on January 1 of the year in which the dependent is no longer claimed on the subscriber's or spouse's tax return. For example, if a 21-year-old child is claimed as a dependent on the subscriber's tax return for tax year 2006, and is not claimed for the 2007 tax year, the two-year extension of eligibility period begins on January 1, 2007 (the first year the dependent is not claimed on the subscriber's federal tax return), and ends on December 31, 2008.

## Q: Does this law change Blue Cross Blue Shield of Massachusetts' policy on student dependent eligibility?

No. Eligibility for students remains the same. Thus, a student dependent who has not been claimed within the past two calendar years as a dependent on the subscriber's or spouse's federal tax return will lose coverage at age 25, when he or she marries, or on November 1 following the date the student discontinues full-time classes or graduates, whichever comes first.

Q: Will Blue Cross Blue Shield of Massachusetts require verification from the subscriber upon initial enrollment of students or dependents?

No. The subscriber's employer is responsible for making eligibility determinations and may require verification from the subscriber upon initial enrollment of students or dependents.

## Q: Will Blue Cross Blue Shield of Massachusetts continue the current student/dependent certification process?

We will not continue our current student/dependent certification process. To help ensure compliance, we will instead conduct an annual notification and auditing process, which will include an annual notification to subscribers with dependents age 18 and over, outlining eligibility requirements and directing them to work with their employers regarding the continuation of eligibility for their dependents, or cancellation of dependents who are no longer eligible. [In addition, we may audit an account's or subscriber's eligibility and request documentation from the subscriber at that time.]

## Q: Are members who work for a Massachusetts fully insured employer, but live outside of Massachusetts eligible for the new dependent coverage?

Yes. The dependent eligibility provision applies to all Massachusetts fully insured employers and their employees, regardless of where the employees live. However, other Subscriber Certificate provisions, such as HMO Blue<sup>®</sup> service area requirements, may limit the benefits a dependent can receive when he or she receives services outside of the service area.

#### Q: Will Blue Cross Blue Shield of Massachusetts require documentation to prove Internal Revenue Code dependency?

We expect employers to validate eligibility of all dependents prior to enrollment. However, Blue Cross Blue Shield of Massachusetts may audit accounts and request eligibility documentation. Blue Cross Blue Shield of Massachusetts may also institute a verification process in the future.

#### How to Enroll Dependents

To enroll eligible dependents, simply complete the dependent's information on the *Enrollment and Change Form* (name, address, date of birth, etc.).

**Remember:** In the **Type of Transaction** section of the *Enrollment and Change Form*, check the "Add" box.

In the **Remarks** section, specify the type of dependent being added, such as "Add newborn," "Add spouse," "Add civil union partner," "Add domestic partner," etc.

For adopted children (both US and foreign adoptions), see pages 3-2 and 3-3 for required documentation.

For **disabled dependents over age 19**, attach *Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form.* 

**Please note:** We encourage you to submit enrollment requests as early as possible. If we receive a notice of a new enrollment to your plan within 60 days of the requested effective date, we will honor that date.

If you do not enroll the new dependent within 60 days of the requested effective date, the dependent is not eligible to enroll until your next open enrollment period.

Do not enclose enrollment requests with your monthly bill payment. This will delay processing of applications and could affect members' coverage.

#### How to Complete the Enrollment and Change Form

The following example shows how to add a new spouse to an employee's contract due to marriage. Use this example for additions or changes that concern dependents. The employee only needs to fill in the shaded area of section 2, and then either section 3 (if adding a spouse), or section 4 (if adding dependents).

See Section 2, *Enrolling Employees in a Health Plan*, for instructions on completing the *Enrollment and Change Form*.

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#### Student and Dependent Eligibility Report

This report will show you three categories of situations:

- 1. Dependents nearing the regular dependent maximum age,
- 2. Students nearing the student dependent maximum age, and/or
- 3. Students going through the student recertification process if applicable to your account. These students will appear on this report up to three times a year—in April, in August, and again in October if the student hasn't responded.

The most common status The same member may appear on up to three you'll see here is "regular," monthly reports. The first time, the report will show "maximum age letter" sent. The second time, it will meaning a regular dependent or "student." show "cancel letter." The third time, it will show Disabled dependents "canceled-no letter" to indicate that the actual will be bypassed by the cancellation has taken place, but no letter maximum age process as was mailed. (See message key, page 3-14.) long as we have approved Please note: If at any time during the three the member's coverage beyond the maximum age. months, the appropriate action is taken to change the Thus, they will never member's status, the member will not appear appear on this report nor on subsequent reports. will they receive a letter. ۲ BlueCross BlueShield This section tells you the PAGE: IONTH ENDING: 04/30/00 REPORT: MDE AGE BC & BS OF MASSACHUSETT TODAY'S DATE: 05/01/00 STUDENT AND DEPENDENT ELIGIBILITY type of benefits the group REPORT CROUP BILLING UNIT: GROUP NAME: 0000000000 CBU: NT NUMBER: 4000011 has. It could be medical, ABC CLEANING SERVICES ACCO dental, or both. It also BENEFITS: gives the maximum age MEDICAL DEP TO 19; STU TO 2 DENTAL DEP TO 19; STU TO 23 to which the member is covered for each benefit. DEPENDENT BENEFIT SUBSCRIBER NAME/ADDR/PHONE STATUS OF IDENTIFICATION DATE OF BIRTH BENEFIT GROUPING CANCEL DATE Coverage ends on the LETTER SENT birthday unless your group 08/21/06 THOMAS JONES STEPCHILD 0011201210000 10 08/21/76 MEDICA DEP MAX AGE LTR has specified otherwise. PATRICIA JONES 300 WINTER ST 08/21/06 If that's the case, any S BOSTON MA 02110 (617) 376-1258 variation is spelled STEVE C SMITH 0015867170000 10 out here. 08/21/76 08/21/06 REGULAR DENTAL DEP MAX AGE LTR MARGARET SMITH 313 SCHOOL ST MA 02116-1610 S BOSTON (617) 482-9615 MICHAEL S CASEY REGULAR 0114321710000 10 05/07/76 MEDICAL 05/07/06 DEP CANCEL LTR SCOTT CASEY 56 WASHINGTON ST, APT 2 This potential W ROXBURY (617) 326-2519 MA 002138 cancellation date is KEVIN W KELLEY WILLIAM KELLEY generally three months 0116521720000 10 04/07/06 REGULAR 04/07/76 MEDICAL CANCEL - NO LTR in the future. At this 1021 ASHMONT DRIVE FRAMINGHAM MA 02131-1241 point, the member is not (508) 969-1409 vet canceled and may THERESA C SHERMAN STUDENT 0117120130000 10 08/07/72 DENTAL 08/07/06 STU MAX AGE LTR avoid cancellation if the MARY S SHERMAN 56 WASHINGTON ST, APT 2 appropriate action is MA 002138 W ROXBURY taken. (For example, (617) 326-2519 a member nearing age SHAWN T CAINES STUDENT 00143217170000 11 05/10/70 MEDICAL 05/10/06 STU CANCEL LTR 25 may be a full-time SCOTT CAINES 56 WASHINGTON ST, APT 6 W ROXBURY MA 002138 (617) 326-2009 student; once we're notified to switch him/her PAUL M KANE STUDENT 0011201210000 11 07/14/72 MEDICAL 11/01/06 UPCOMING RECERT to a student status, the PATRICIA KANE DENTAL 11/01/06 cancellation will not be 300 WINTER ST S BOSTON (617) 376-1258 MA 02110 processed.)

Message Key for Let	ter Sent Column—If Applicable to Your Account
UPCOMING RECERT:	Letter mailed to a parent in May advising, if their student is graduating in May, to please let the employer know now. Otherwise, we'll ask student to recertify in September.
STU RECERT FORM:	Letter mailed to a parent in September with the <i>Student Certification Form</i> enclosed. This form must be returned by October 15.
STU RECERT CXL:	Letter mailed to a parent in November if we haven't received their son or daughter's <i>Student Certification Form</i> . The letter states that their student was canceled as of November 1.
DEP MAX AGE LTR:	Letter mailed three months before a regular dependent turns age 19.
DEP CANCEL LTR:	If we've received no response to our first letter, a follow-up letter is mailed approximately one month before the birthday, advising that the dependent will soon be canceled.
STU MAX AGE LTR:	Letter mailed three months before a student dependent turns age 23 or age 25.
STU CANCEL LTR:	If we've received no response to our first letter, a follow-up letter is mailed approximately one month before the birthday, advising that the student dependent will soon be canceled.

#### Type of Contract Adjustment Report

This report is geared toward accounts with more complex financial arrangements. It will alert you to adjust the subscriber's membership if you offer three-tier rates of contract. If the number of members on the contract decreases, you will realize savings on your premium bill if you quickly adjust the membership, or transfer the membership from family to two-party or from two-party to individual.



#### 

REPORT: TOCCHNGE TODAY'S DATE: 04/01/06		BC & BS OF TYPE OF CON REPOR	FRACT				PAGE: DING:03/31/00	
GROUP BILLING UNIT: GROUP NAME:	OUP BILLING UNIT: 006007771-0000							
MEMBER NAME	MEMBER RELATION	IDENTIFICATION NUMBER		DATE OF BIRTH	CURRENT TYPE OF CONTRACT	CURRENT NUMBER OF MEMBERS	CANCEL DATE	
MICHAEL S CASEY	DEPENDENT	0124321710000	10	07/07/76	119-FAMILY	03	07/07/00	
SHAWN T CAINES	DEPENDENT	0214321710000	11	07/10/70	119-FAMILY	03	07/10/00	
TERRI M CHURCH	SPOUSE	0111431370000	00	06/13/30	127-FAMILY	03	06/01/00	
		** END OF RE	PORT	* *				

## EnrollmentWHAT DO WE NEED TUnderwritingCompleted applicat

#### WHAT DO WE NEED TO ENROLL A NEW DEPENDENT?

Completed applications received within 60 days of requested effective date with a qualifying event of:

New hire—completed and signed application.

Spouse due to marriage or partner of a civil union—completed and signed application.

**Spouse/dependents due to loss of coverage**—completed and signed application and HIPAA certificate.

Newborn on a family plan, or female individual plan—completed and signed application.

Newborn on a male individual plan-completed and signed application.

Domestic partner—completed and signed application (accounts with rider only).

**Student dependent**—completed and signed application and copy of a Student Certification Affidavit or copy of statement showing payment of tuition.

**Please Note:** The date of the start of the semester must be on the document to determine the qualifying event date.

**Dependent/spouse coming into the country**—completed and signed application and copy of passport with date-of-entry stamp.

**US Adoption**—completed and signed application and a signed letter from the Adoption Agency indicating the exact date of placement.

Foreign Adoption—completed and signed application, official government papers (translated into English), copy of child's passport (including a page showing a U.S. Customs and Border Protection date stamp), or a letter from a United States licensed adoption agency, stating the date of placement.

**Dependent by court order**—completed and signed application and a copy of the court order.

**Please Note:** Applications received <u>beyond 60 days</u> from the requested effective date are subject to Underwriting approval. Additional information (i.e., marriage certificate, subscriber's signed and dated enrollment application, or birth certificate) may also be required. Please contact your Account Service Representative for instructions.



# New Member Information

• Member Identification Cards and Numbers

#### **NEW MEMBER INFORMATION**

#### Member Identification Cards and Numbers

Following enrollment, we send identification cards directly to the homes of those employees who have joined our plans or plans administered by us.

If the employee selects a **managed care plan**, we send cards to all enrolled family members. Employees in **other plans** receive cards only for themselves and their spouses. However, if their plan has a prescription drug program with copayments, student dependents, if any, will receive their own identification cards.

We issue an identification number that includes a three-letter prefix. The three-letter prefix identifies the type of plan the subscriber has selected.

If a member's identification card is lost or stolen, please contact your Account Service Representative to arrange for a replacement card. Or, the member may call his or her Member Service center directly to arrange for a replacement card.



# Changing a Member's Status

There are times when a member who is enrolled in a health plan may need to change his or her membership status. Examples are name, address, and coverage change. We've simplified the process by using one form for most changes: the *Enrollment and Change Form*. This section explains:

- Changing Status
- Transferring Coverage
- Terminating Coverage
- How to Change a Primary Care Physician

#### Paper Changing Status

The Enrollment and Change Form is used for most membership status changes. Some status changes, such as a dependent child becoming an eligible full-time student, require a different form. The page numbers in parentheses below direct you to an example of how to complete the appropriate form when changing a member's status.

You can make the following changes at any time:

- Name (5-2)
- Address (5-2)
- For managed care plans: You may change your primary care physician anytime after enrollment (changes for New England plans are effective on the 1st of the following month) (5-7)
- Member becomes eligible for Medicare (7-1-7-15)

Other changes are effective on the date of a member's qualifying event. These events include:

- Marriage of the subscriber (5-2)
- Civil union (5-2)
- Divorce of the subscriber (5-2)
- Birth, legal guardianship, or adoption of a dependent child (5-2)
- A dependent child becomes an eligible full-time student (5-2)
- A dependent child reaches the maximum age limit for coverage under a family contract (5-6)
- A member reaches age 65 (7-14)
- Death of a member (5-6)

All other changes are effective only on your group's contract renewal date.

- *Accounts* can enroll in BlueLinks to update employees' information (located on our website **www.bluecrossma.com**).
- *Employees* can register to update their information (located on our website **www.bluecrossma.com**).

An employee's membership can be transferred only if the following conditions exist:

Electronic Changing Status

The following example shows how to change an address. You may also use this example for some of the other member changes listed on the previous page.

MASSACHUSETTS	Before Fillin	The Instruction g Out This Form			nent and Change For 20. Box 9145, North Quincy, MA 02171-
Cross Blue Shield of Massachusets is an independent see of the Blue Cross and Blue Shield Association To Bc Filled Out by Your Empl		avoid coverage delay.			
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You Covered Part A Effective Date	Part B Effective Date	B. C	City/	Medicare #	A Is this your current PCP? Mark X, if yes. Actively Working
Y M DO YYY	MM DD	1117 M	DD 1111	65+ Disabled	ESRD If Retired, Date:
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mber 2's First Name		M.I. Last Name			Sex Date of Birth
eet Address / P.O. Box #	Apt.	# City/Town		State Zip	Code Do YYYY
Social Security # Telepho	nc # (area code)	Other Insurance	• Other Heal	th Insurance Company Name	City/State
PCP ID #: (see instructions)	) Name of PC	Y/N		State	Is this your current PCP? Mark X, if yes.
dember 2 Part A Effective Date	Part B Effective Date	Part D	Effective Date	Medicare #:	Actively Working
Medicare?*	MM DD		DD 1997	65+ Disabled	Y/N ESRD If Retired, Date:
* If you have	ot indicated Yes or No regar	ding your Medicare of	other insurance status, y	ou may receive a follow-up quest	ionnairs.
Tell Us About Your Dependent: pendent's Fint Name	s (Members 3, 4, an	d 5) M.L. Last Name			
		M.L. Last Name	1 1 1		Sex Full-time student? Age 19 or over
Social Security # Date of 1		PCP ID Number (see	instructions)	Name of PCP	Is this your current PCP Mark X, if yes.
pendent's First Name	1 1 1	M.I. Last Name	1 1 1		Sex Full-time student? Age 19 or over
Social Security # Date of 1	Sirth	PCP ID Number (see	instructions)	Name of PCP	Is this your current PCP
pendent's First Name		M.I. Last Name	1 1 1		Mark X, if yes. Sex Full-time student? Age 19 or over
Social Security # Date of I	linth	PCP ID Number (see	instructions)	Name of PCP	Is this your current PCP
ase check if you are using separate forms for ad	dirional dependent children			Total # of Dependents:	Mark X, if yes.
Select Personal Savings Account	-			Total - or Expendence	
HSA Start Date	End Date		FSA G	OAL AMOUNTS: (Please see i	nstructions for maximum limits
FSA - Health Start Date	End Date		Health \$:		
FSA - Dep. Start Date	End Date		Dependent Care \$:		and have been and
Signatures (Employer & Employ ne information here is complete and tra anges to my membership. I understan y restrictions that apply to my health c business, and that it may use and disc d disclosure of my information in "Our	e. I understand that B d that I should read the are plan. I understand t ose that information in	subscriber certific that Blue Cross and accordance with	cate or benefit book d Blue Shield may o law. I acknowledge	let provided by my emplo obtain personal and medic that I may obtain further i	yer to understand my benefits and al information about me to carry on information about the collection, u

#### **Remember:**

- When changing a member's name or address, write "Name change" or "Address change" in the Remarks section.
- When changing status due to divorce, change membership to individual coverage if dependents are no longer covered and write "Change membership to individual due to divorce." in the Remarks section.
- When changing status due to birth, legal guardianship, or adoption, make sure to add all appropriate dependent information in the Dependent sections and describe the type of dependent change in the Remarks section.

**Important note:** Please review forms carefully before submitting. Be sure to describe the requested transaction in the Remarks section.

#### Transferring Coverage

An employee's membership can be transferred only if the following conditions exist:

• During your Account's open enrollment period, a subscriber transfers from one plan which is administered by Blue Cross Blue Shield of Massachusetts to another plan administered by Blue Cross Blue Shield of Massachusetts. (If you are processing requests through BlueLinks, you must order ID Cards.)

Examples of when a member **may** be eligible to transfer his or her coverage:

- A member in a managed care plan who moves outside the enrollment area **may** be eligible to transfer his or her coverage. Please consult with your Account Service Representative for more information.
- An account who established a Section 125 Trust Plan (cafeteria plan) and requests to transfer a member from one plan which is administered by Blue Cross Blue Shield of Massachusetts to another plan administered by Blue Cross Blue Shield of Massachusetts. If we receive an enrollment request that does not comply with our eligibility policy, but it does comply with the employer's Section 125 Trust Plan, the request can be approved with documentation of the employer's qualifying events as filed with the **IRS**.

The following example shows how to transfer a subscriber from one group to another during open enrollment.

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#### Terminating Coverage

Coverage for the employee (and enrolled dependents) ends when:

- The group is terminated for non-payment of premiums or changes.
- The group does not renew the contract with Blue Cross Blue Shield of Massachusetts.
- The subscriber is no longer eligible for group coverage because he or she no longer meets the eligibility requirements imposed by your group or by us.
- The subscriber (or a covered dependent) is no longer eligible for coverage as a result of misrepresentation or fraud.
- The subscriber (or a covered dependent) misuses the Blue Cross Blue Shield of Massachusetts identification card to obtain coverage for which he or she is not eligible under his or her contract. Or, the member misuses the Blue Cross Blue Shield of Massachusetts identification card by permitting another person not enrolled for coverage in that plan to attempt to obtain coverage under the contract. Termination will go back to the effective date or date of the misrepresentation or fraud.
- The subscriber or dependent commits an act (or acts) of physical or verbal abuse that may pose a threat to the network providers or other members and that are not related to the member's physical or mental condition. Termination will follow procedures approved by the Massachusetts Commissioner of Insurance.
- The subscriber dies. (If the surviving dependents are eligible for continued coverage, a new enrollment request must be submitted.)
- A Medicare-eligible subscriber reaches age 65 and retires (or is already retired). See Section 7, *When a Member Becomes Eligible for Medicare*.
- The subscriber voluntarily ends coverage or leaves employment.

Coverage for a former spouse ends when:

• The divorced spouse of the subscriber is no longer eligible for coverage.

Coverage for an **enrolled dependent** ends when:

- The subscriber's coverage ends, as described above.
- The dependent child reaches age 26. There are two exceptions:
  - Your contract has special provisions for full-time students.
  - We determine that the dependent child is physically or mentally disabled and incapable of self-support. See Section 3, *Enrolling Dependents in a Health Plan*.
- The dependent child marries.
- The spouse reaches age 65 and becomes eligible for Medicare. An exception is when the subscriber remains an active employee of a group of 20 or more employees and this contract is chosen for the primary coverage. See Section 7, *When a Member Becomes Eligible for Medicare*.

Call Your Account Service Representative for More Information on This Subject

Coverage for a student dependent terminates when:

- The subscriber's coverage is terminated, as described above.
- The student reaches the maximum age for coverage, as stipulated in your contract.
- The student marries.
- The student discontinues full-time classes or graduates. In this case, coverage ends on the following November 1 or on the date the student otherwise loses eligibility for student dependent coverage, whichever comes first.

## Important information for an employee (or dependent of an employee) whose coverage is ending:

Blue Cross Blue Shield of Massachusetts has many plan options to fit most budgets and lifestyles. To find out more about or to enroll in one of our plans, please call us at one of the following toll-free numbers weekdays, 8:00 a.m. to 5:00 p.m. EST, or visit us at **www.getbluema.com**.

• For members under age 65:	1-800-422-3545
• For members over age 65:	1-800-678-2265

Call Your Account Service Representative for More Information on This Subject

An example of a member's voluntary termination follows. You may also use this example for the other terminations shown on pages 5-4 and 5-5.

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**Remember:** When terminating a member's coverage, indicate the reason for the termination in the Remarks section, such as "Terminate dependent child coverage due to marriage." Both the employee and the employer must sign voluntary termination forms.

**Important note:** Please review forms carefully before submitting. Be sure to describe the requested transaction in the Remarks section.

#### How to Change a Primary Care Physician

(Applies to managed care plans only)

To change a Primary Care Physician (PCP), the employee completes the *Enrollment and Change Form* and returns it to the address on the form. **Note:** Members may also call their Member Service Center or Physician Selection Service at **1-800-821-1388** to make this change over the phone. The member may also change his or her PCP online at **www.bluecrossma.com**.

The change will be effective on the day Blue Cross Blue Shield of Massachusetts receives the member's request under any local managed care plan, such as **HMO Blue**<sup>®</sup> or **Network Blue**<sup>®</sup>.

The change will be effective on the first day of the month following the date Blue Cross Blue Shield receives the member's request under a New England managed care plan, for example **HMO Blue® New England**, **Network Blue New England**, or **Blue Choice® New England**. The member should consult with his or her new PCP for referrals for continued care.

The following Enrollment and Change Form shows how to change a member's PCP.

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Call Your Account Service Representative for More Information on This Subject



# Continuation of Coverage

Continuation of coverage is provided through COBRA, or the Massachusetts equivalent. This section describes:

- COBRA
- Massachusetts continuation of coverage
- Blue Cross Blue Shield of Massachusetts nongroup plans

#### **COBRA**

#### Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is an acronym for the federal law known as the *Consolidated Omnibus Budget Reconciliation Act of 1986.* A provision within COBRA (*Title X*) addresses the right of certain former group health plan members to continue their group coverage for a specific period of time under specific conditions. Employers, including those with self-funded group health plans, who had at least 20 employees on 50 percent of business

days during the previous calendar year must comply with COBRA. If a group health plan is maintained by an affiliated group of employers, all employers within the plan must comply with COBRA if the affiliated group in the aggregate had 20 or more employees. While COBRA rights and requirements are similar to Mini-COBRA, you may wish to speak with an attorney regarding your COBRA obligations.

#### **Mini-COBRA**

#### **Massachusetts Continuation of Coverage (Mini-COBRA)**

Chapter 176J is the state law that governs health care coverage for small businesses (businesses with 1–50 employees). Section 9 of Chapter 176J requires continuation of group health coverage for employees in insured groups with 2–19 employees.

#### Who Is Eligible for Mini-COBRA Continuation of Coverage Provisions?

Generally, an employee, former employee, spouse, or dependent child who was covered under most insured group health plans on the day before a "qualifying event" is eligible for continuation of coverage. These people become "Qualified beneficiaries" with the right to elect continuation of group coverage. qualified beneficiaries have the right to elect and continue coverage even if the coverage is a managed care plan, such as HMO Blue<sup>®</sup>, Blue Choice<sup>®</sup> or Access Blue<sup>TM</sup>, and the qualified beneficiary moves outside the plan service area. It is your responsibility to remind the qualified beneficiary that, in general, benefits are only available for emergency and urgent care services outside the plan service area.

#### What Is a Qualifying Event?

A qualifying event is one of the following circumstances that causes the loss of coverage:

1. Termination of employment (except for termination due to gross misconduct). This includes:

- voluntary resignation
- involuntary termination
- retirement
- layoff
- reduction of work hours (e.g., work stoppage, employee begins a leave of absence, changes from full-time to part-time)
- 2. Death of the employee.

- 3. Divorce or legal separation.\*
- 4. Loss of eligibility for a dependent child (e.g., overage dependent/student).
- 5. Employee becomes entitled to Medicare.
- 6. Retiree (or surviving spouse of a deceased retiree and their dependent children) loses coverage due to his or her former employer's bankruptcy proceedings.\*\* (Separate bankruptcy laws may prohibit you from terminating retiree coverage after bankruptcy is filed. You may wish to speak with an attorney regarding your bankruptcy obligation.)
- \* A divorced or separated spouse may have different continuation rights due to state-mandated benefits specifically for divorced and separated spouses. You may wish to consult with your legal counsel about this mandate.
- \*\* A loss of coverage in the bankruptcy context is a substantial elimination of coverage within one year before or after the bankruptcy proceeding commenced.

#### How Long Does the Mini-COBRA Continuation of Coverage Last?

Up to 18 months for qualifying event (1) on previous page.

**Please note:** A qualified beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled at the time of a qualifying event involving termination or reduction in work hours may be eligible to continue coverage for up to an additional 11 months (29 months total). In addition, if a qualified beneficiary involved with a termination of employment or reduction of work hours is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of Mini-COBRA coverage, such qualified beneficiary is also eligible under Blue Cross Blue Shield of Massachusetts guidelines and policies to continue coverage for up to an additional 11 months (29 months total). The qualified beneficiary must request the extension before the end of the 18-month period and must not be eligible for Medicare. If the individual entitled to the disability extension has non-disabled family members are also entitled to the 29-month disability extension.

Up to 36 months for qualifying events (2), (3), (4), and (5).

For qualifying event (6), affected retirees and surviving spouses of deceased retirees are entitled to elect and pay for lifetime mini-COBRA coverage as of the date of the bankruptcy proceeding. Spouses and dependent children of retirees are entitled to mini-COBRA coverage until the retiree dies. Once the retiree dies, his or her surviving spouse and dependent children, if any, are entitled to elect and pay for an additional 36 months of coverage from the date of the retiree's death.

## Can Qualified Beneficiaries Change Coverage During the Mini-COBRA Period of Coverage?

If a qualified beneficiary elects to continue coverage under mini-COBRA and an open enrollment period for active employees occurs while the qualified beneficiary is still receiving the mini-COBRA continuation of coverage, the qualified beneficiary must be offered the opportunity to switch coverage to another plan the employer offers to active employees during the open enrollment.

#### What Are the Employer's Responsibilities?

As an employer, your responsibilities to your employees regarding coverage include the following:

- To provide each employee and spouse with notice of their continuation of coverage rights at the time they enroll in coverage.
- To provide each qualified beneficiary with notice of his or her election rights within 14 days of knowledge of a qualifying event. The qualified beneficiary must provide you with notice of certain qualifying events (See qualifying events #3 and #4 on page 6-2) within 60 days of the event.
- To allow each qualified beneficiary 60 days from the date coverage was lost because of the qualifying event (or the day you provide notice, whichever is later) to make their continuation of coverage election. The day they make the election is their "election date."

See sample notice on pages 6-7 and 6-8, and sample election form on page 6-9. You may wish to refer to these forms in drafting your forms.

#### How Much Does Continuation of Coverage Cost the Qualified Beneficiary?

You may charge up to 102 percent of the premium for all continuation periods. However, if the qualified beneficiary is in the extra 11-month period due to disability, you may charge up to 150 percent of the premium during that 11-month period.

#### When Are the Premiums Due?

The qualified beneficiary has 45 days from the election date to make the first payment to you. The first payment is for the period from the date the person's group coverage ended, through the current month. Reinstatement will not be allowed if the payment is not received within the 45-day time period. Subsequent premium payments are due monthly on your regular billing cycle.

#### When Can An Employer Cancel the Mini-COBRA Continuation of Coverage?

An employer may cancel a member's continuation of coverage in the following situations:

- When the qualified beneficiary fails to pay the premium in a timely manner.
- When the qualified beneficiary becomes entitled to Medicare after electing continuation of coverage.
- When the employer discontinues all group health plans.
- When the qualified beneficiary becomes covered under another group health plan, which does not contain any exclusions or limitations (i.e., waiting period/pre-existing condition clauses) after electing continuation of coverage.

## What Happens When the Qualified Beneficiaries Reach the End of Their Continuation Period?

The qualified beneficiaries are given the option to enroll in a direct-pay plan.

#### How Do I Administer Enrollment of the Member?

Once the qualifying event has occurred, and you have informed the member of his or her continuation of coverage rights, we request that you cancel the member immediately from your group. Canceling the member will accomplish two things:

- Removes you from the financial burden of paying for the member's premium while he or she is deciding whether to accept or decline the continuation of coverage.
- Offers the member one of our direct-pay plans; the member would then have two options to choose from (continuation of coverage or direct-pay).

If the member accepts the continuation of coverage within the 60-day time period, and subsequently pays the premium to the paid-through date (within the 45-day window), he or she will have coverage reinstated, retroactive to the qualifying event.

#### How Do You Bill a Member on Mini-COBRA Continuation of Coverage?

Once a member has opted for continuation of coverage, and has been reinstated in your group, we will bill you for the member on a monthly basis. It will appear as if the member were still an employee of your company. It is your responsibility to monitor and receive their monthly payment. In the event that you have difficulty collecting payment from Mini-COBRA members, please call your Blue Cross Blue Shield of Massachusetts billing representative at the phone number listed on your monthly premium bill.

#### **Example of Continuation of Coverage Timelines:**

John Smith leaves XYZ Corp. on May 24, 2008. XYZ Corp.'s policy is to provide extended coverage until the end of the month (billing cycle) for all terminated employees. XYZ Corp. submits an *Enrollment and Change Form* to Blue Cross Blue Shield of Massachusetts to cancel the member effective June 1, 2008.

The employer notifies Mr. Smith on June 1, 2008 (qualifying event), via certified mail, that he has continuation of coverage benefits available. Mr. Smith has 60 days from June 1 to notify XYZ Corp. whether he wishes to accept or decline continuation of coverage.

On July 31, 2008, Mr. Smith advises XYZ Corp. that he wishes to elect continuation of coverage (election date). Mr. Smith now has an additional 45 days to pay the premium for the continuation of coverage to the employer. If he waits until the 44th day (September 13, 2008), payment in this example would be for five months of premium (June through October).

Once payment has been made, XYZ Corp. advises Blue Cross Blue Shield of Massachusetts Mr. Smith's continuation of coverage election, and submits an *Enrollment and Change Form* to reinstate Mr. Smith back to June 1, 2008.

#### Blue Cross Blue Shield of Massachusetts Nongroup Plans

This example provides one of the few exceptions in which Blue Cross Blue Shield of Massachusetts would allow a change in coverage beyond the customary 60-day retroactive period.

5/24/08	Member leaves company
6/01/08	Qualifying event (last day of coverage)
7/31/08	Election date (60 days available)
9/14/08	Premium received (45 days available)

This information provides highlights of the continuation of coverage provisions of Mini-COBRA. If you have any questions, please call your Account Executive at their direct line phone number or via our general phone number at **1-617-246-5000**.

When a member's coverage in a group plan is terminated (either voluntarily or involuntarily), Blue Cross Blue Shield of Massachusetts notifies that member by letter of continuation of coverage options that may be available to him or her upon termination. Those options include:

- continuation of group coverage under COBRA or applicable state law, or
- enrollment in one of our nongroup direct-pay (as on page 6-4) plans.

Please understand that our notice to members does not replace or satisfy your obligations to notify members of their rights to continue group coverage with you under COBRA or applicable state laws. You still have a responsibility under these laws to provide such notice to your employees.

Beginning January 1, 1998, state law requires that only standardized plans can be offered in the nongroup market. If a member is eligible, Blue Cross Blue Shield of Massachusetts can offer him or her a choice of plans. To find out more about or to enroll in one of our nongroup plans, members may call **1-800-822-2700** for information and a rate quote (rates vary by age and place of residence).

State law governing nongroup plans does not allow us to enroll any individual who resides outside of Massachusetts. These members can either:

- 1. continue group coverage under COBRA or applicable state law,
- 2. contact Member Service for information about Blue Cross Blue Shield of Massachusetts nongroup plans that may be available to them in their state of residence that they may apply for directly, or
- 3. contact the Insurance Department in their state of residence for other coverage options.

	:
becau were own e	come to our attention that you will no longer be eligible for coverage under your group health plan ise of the situation checked off below. State law gives you (and your spouse and/or dependents if the covered under your plan) the right to continue coverage under your present group health plan at you expense if you wish. The length of time you may continue coverage is shown under each ion listed below.
	Death of an employee
	The surviving spouse and/or any dependent children may continue group coverage for up to 36 months.
	The employee becomes ineligible for group health coverage after termination of employment or reduction of work hours.
	All family members covered under the employee's health plan may continue group health coverage for up to 18 months. Note: If you are qualified for Medicare disability at the time you lose coverage or within 60 days of your loss of coverage, you must notify us 60 days before the end of the 18-month period to continue coverage for an additional 11 months. The premium for the additional 11 months may be up to 150 percent of the premium for active employees.
	Divorce or legal separation
	The spouse and/or any covered dependent children may continue group health coverage for up to 36 months.
	The employee becomes entitled to Medicare coverage.
	The spouse, if not also enrolled in Medicare, and/or any dependent children may continue group coverage for up to 36 months.
	A child ceases to be a dependent under the employee's family membership.
	The child may continue group coverage for up to 36 months.
	A retiree substantially loses coverage within one year before or after we file for bankruptcy.
	The retiree, spouse, and/or dependents may continue coverage until the death of the retiree, or up to 36 months after the death of the retiree for the qualified surviving spouse and dependents.
	ugh you are allowed by law to continue group health coverage at your own expense under the above nstances, continued coverage will be terminated if:
We	cease to maintain a group health plan/or,
You	a fail to pay the premium on time/or,
	a are covered by another group health plan which does not contain any exclusion or limitation with pect to any pre-existing condition/ or,
You	are entitled to Medicare benefits.
	r the law, you have 60 days to decide whether to stay in your present group health plan. (The ine for your decision is shown on the <b>Date Continuation Option Expires</b> line on the reverse side s form.)

Notice of Right to Continue Group Health Coverage for Mini-COBRA Form (Front)

Check the <b>Yes</b> box.	
If you (or your spouse and/or dependants) do not	wish to continue group health coverage:
Sign the Beneficiary Election Form.	
Check the No box.	
Indicate the reason(s) you do not wish to continue	e coverage.
If you decide to continue coverage, your first paymen your <b>Beneficiary Election Form</b> . This bill will cove begins (shown below on the <b>Effective Date of Cont</b> your <b>Beneficiary Election Form</b> . (Please note, there make your decision within 30 days.)	r the time period from the date continued coverage inued Coverage line) through the month we recei
Once you have made the first payment for continued percent of the group rates. (The additional two percent expenses that are involved in keeping you in the group payment may be lower.) The current monthly group re- when the group rate changes (usually once a year).	nt is allowed by law to cover the extra administrativ p. In certain circumstances under state law, your
If you choose to continue coverage under the group h the Plan provides for similarly situated employees and	1
For Office Use Only	
Beneficiary Name:	Monthly Group Rate:
	Group Number:
Contract Number:	
Date Continuation Option Expires:	
Date Continuation Option Expires:	

Notice of Right to Continue Group Health Coverage for Mini-COBRA Form (Back)

I am aware expense.	e that coverage under my current health plan can be extended for a certain length of time at n
Check one	box:
🗆 Ye	es, I choose to continue in my group level health benefit program.
	y spouse and/or dependents were covered under my health benefit program and they so choose to continue coverage.
	o, I do not wish to continue in my current health benefit program. [If you choose not not intinue group insurance, please check off the applicable reason(s).]
	□ I have other group health insurance coverage.
	□ I have elected to convert to nongroup coverage.
	□ I am moving out of state.
	□ This coverage is too expensive.
	□ Other:
Signature	: Date:
Current	Address:
Guilent P	Iuuress
	YOU MUST RETURN THIS FORM BY THE DATE SHOWN BELOW ON THE "ELIGIBILITY EXPIRES ON" LINE
Eligi	bility Expires on:
1	unt Name:
Cont	act Name:
	et Address:
City.	State, Zip Code:

Beneficiary Election Form to Continue Group Coverage



## When a Member Becomes Eligible for Medicare

Medicare Members Please note: Employers should seek the advice of their own legal counsel for MSP (Medicare Secondary Payer) interpretation issues or questions.

There are three reasons people become entitled to federal Medicare Health Insurance coverage:

1. Aged Entitlement

A person becomes entitled to Medicare coverage on the first day of the month in which the person reaches age 65 or on the first day of the previous month if the person's birthday is the first of the month.

**Example:** 65th birthday is August 2 through August 31—Medicare effective date is August 1. 65th birthday is August 1—Medicare effective date is July 1.

**Please note:** When an employee becomes eligible for Medicare and continues to work, or when an active employee's spouse becomes eligible for Medicare, he or she is subject to the Working Aged Provision of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA (or the Working Aged law) extends an employee's (and spouse's) options for health insurance protection when an active employee or spouse reaches age 65. TEFRA applies to companies that employ a minimum of 20 employees (during at least 20 weeks of the previous or current calendar year).

2. Disability Entitlement

A person, under age 65, becomes entitled to Medicare coverage on the first day of the 25th month in which the person has received Social Security disability benefits.

**Example:** The first Social Security disability benefit check covers the month of September—Medicare effective date is September 1 two years later.

3. ESRD Entitlement (End Stage Renal Disease—Permanent Kidney Failure)

A person of any age who is diagnosed with ESRD becomes entitled to Medicare coverage on the first day of the month in which the person is admitted to a hospital to receive a donor kidney; or on the first day of the month in which the person begins a program of self-administered dialysis at home; or on the first day of the fourth month following three months of provider-administered dialysis at a health facility.

**Examples:** The inpatient admission date is May 29 and the donor kidney transplant surgery takes place on June 2 during that same admission—then the Medicare effective date is May 1.

The person begins a program of home dialysis on November 21—then the Medicare effective date is November 1. The person begins a program of dialysis at a facility on April 19—then the Medicare effective date is July 1.

Medicare is the secondary payer and the employer's group plan is the primary payer for certain employers and certain Medicare members under the Working Aged (TEFRA), the Disability, and the ESRD Medicare Secondary Payer (MSP) laws:

MEDICARE IS SI	ECONDARY PAYER WHEN	
MSP LAW	EMPLOYER HAS:	MEDICARE MEMBER IS
Working Aged	*20 or more employees	- age 65 active employee - age 65 spouse of an active employee
Disability	**100 or more employees	<ul> <li>under age 65 active employee</li> <li>under age 65 dependent of an active employee</li> </ul>
ESRD	all employers	- under age 65 active employee/retiree - under age 65 dependent of an active employee/retiree

#### FOR THE FIRST 30 MONTHS OF THE ESRD MEDICARE ENTITLEMENT

- \* 20 or more full-time and/or part-time employees during 20 or more weeks in the current or previous calendar year. All active employees, including part-time or other employees who may not be eligible for the employer's group health insurance, must be counted to determine if the employer is subject to the Working Aged MSP law.
- \*\* 100 or more full-time or part-time employees on a typical business day during the previous calendar year. All active employees, including part-time or other employees who may not be eligible for the employer's group health insurance, must be counted to determine if the employer is subject to the Disability MSP law. Also, employers of fewer than 100 employees who are part of a Joint Purchasing Agreement (JPA) or a Multiple Employer Trust (MET) are subject to the Disability MSP law if at least one employer in the JPA or MET has at least 100 employees.

#### WHEN A MEDICARE MEMBER IS SUBJECT TO A MEDICARE SECONDARY PAYER LAW

That member cannot be enrolled in the employer's group plan that is a Medicare supplement or Medicare wrap or Medicare replacement plan and the employer may not: induce the member to elect Medicare as primary payer (election is allowed under the Working Aged law); or prevent the member from enrolling in the employer's primary plan; or sponsor or contribute toward any plan for the member that pays secondary to Medicare.

Please note: Please contact your Account Service Representative for instructions.

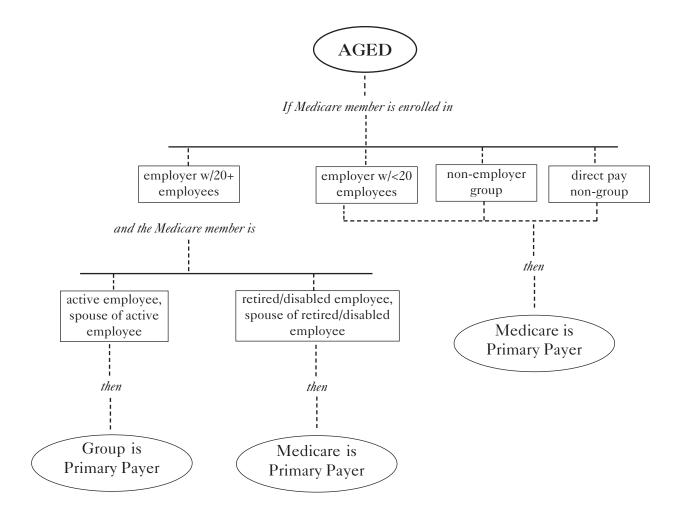
Your Company—For purposes of this document Your Company includes any other corporations that are part of the same controlled group of corporations or affiliated service group of corporations such as a parent company, even if not all of the corporations participate in the same health care plan through Blue Cross Blue Shield of Massachusetts. Thus, for purposes of this questionnaire, you should count the employees of all controlled or affiliated corporations. If you participate in a multiple employer health plan, where two or more unaffiliated companies offer a single health plan to their employees, Your Company means the company with a greater number of employees at any given time.

**Employee**—For purposes of this questionnaire, an **employee** is defined as an individual who received payments from the employer that are subject to FICA taxes. A self-employed company owner is NOT counted as an employee. A retiree is only counted as an employee if they are receiving payments subject to FICA taxes. (For example: working as a consultant.) All employees meeting the definitions above should be counted regardless of their status as full-time or part-time employees, leased employees, consultants, or seasonal employees.

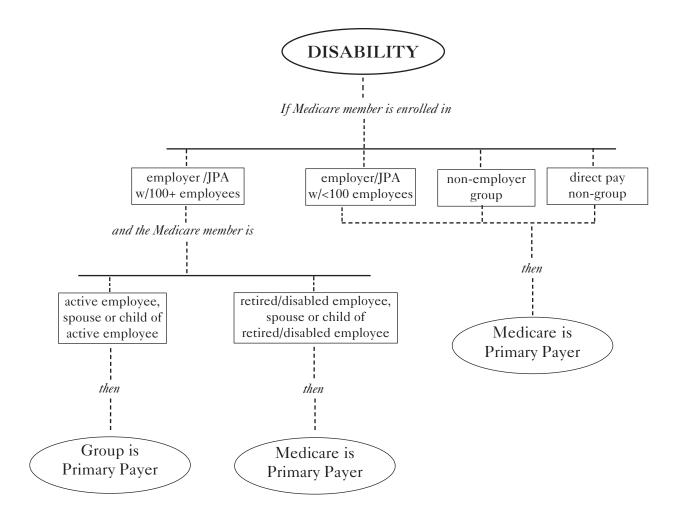
This is a sample of the Medicare Secondary Payer (MSP) letter and survey.

MASSACHUSETTS		
September 18, 2006		
Sample Company Mary Simpson		
426 Main St. Springfield, MA 01151		
Account Number: 1234567		
Dear Mary Simpson: In order to help you comply with federal Medicare Secondary Blue Cross and Blue Shield annually with Your Company's sta determined by the number of employees employed by Your C information may result in incorrect payments for your em your group under MSP laws. For the purpose of this surv on the back of this form.	atus under MSP laws. MSP status is ompany. Failure to supply updated ployees' claims and may raise issues for	
Please indicate the number of employees in Your Company for checking off the corresponding employee count range or rang your employees regardless of their participation in a Blue Cross	es on the enclosed card. Include all of	
Our current records indicate that the total number of employee 1 - 19. If this information has not changed, please check the l employee count did change in the 2005 or 2006 calendar yea employee count range box on the enclosed postcard, indicate the Medicare time requirements for the category you checked	box indicating no change. However, if your rs, please check off the applicable the Month and Year that your company met	
Please complete the enclosed card and mail or fax to the follo	wing address:	
Blue Cross Blue Shield of Massachusetts Or fax to: 402 PO Box 69006 Omaha, NE 68106-9914	2-384-6695	
For your convenience, we have enclosed a "Frequently A again, please don't forget to refer to the important definiti		
Thank you for your assistance.		
Blue Cross Blue Shield of Massachusetts		
Business Hours Monday – Friday 8:30AM – 4:30PM EST	Medicare Secondary Payer (MSP) Survey: Account Please indicate the number of employees in Your Company for the 2005 and 2006 corresponding employee count range or ranges in the boxes below. In the second	calendar years, by checking off the
An Independent Licensee of the Blue Cross and Blue Shield Association.	1 – 19 employees for 33 or more weeks in the calendar year     20 – 99 employees for <b>20 or more weeks</b> during the calendar year     100 or more employees for 50% or more of your regular business days during the calendar year.	□2005 □2006 □2005 □2006 □2005 □2006
	THE EMPLOYEE RANGE OF 1 - 19 HAS NOT CHANGED IN THE CALENDAR YEA	
	IF THE EMPLOYEE RANGE DID CHANGE FROM 1 - 19 IN 2005 OR 2006, PLEASE IN COMPANY FELL INTO THE CATEGORY YOU CHECKED ABOVE 2005 2005 2006	DICATE THE MONTH IN WHICH YOUR
	January         July         January         J           □         February         August         □         February         J           □         March         □         September         □         March         S           □         April         □         October         □         April         □         October         □         April         □         May         □         N	uly ugust eptember ctober ovember ecember
	By signing and returning this form to us you certify the accuracy of the information and co rely on your answers to process your daims in accordance to MSP law. Please return t no later than 9/28/06. If you have any questions regarding this form, please contact us	onfirm your understanding that we will he completed and signed form to us
	Group Administrator's Name (Please Print) Group Administrator's Signatu	re Today's date

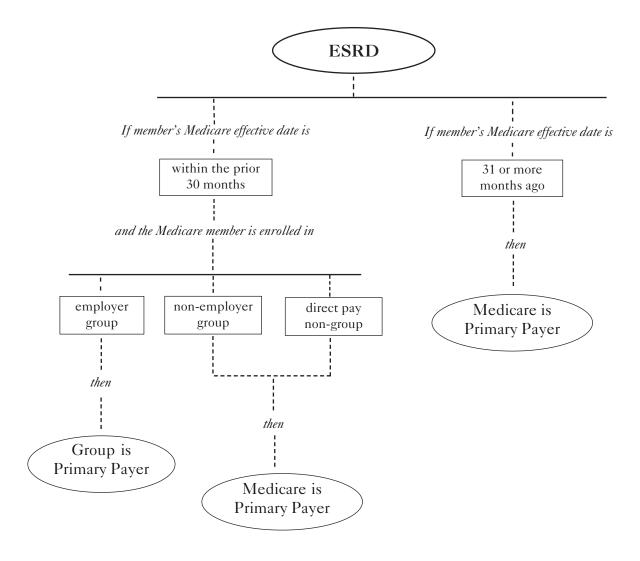
Primacy decision under Medicare secondary payer (MSP) laws when the Medicare member is 65+ and entitled to Medicare based solely on age.



Primacy decision under Medicare secondary payer (MSP) laws when the Medicare member is entitled to Medicare based solely on disability.



Primacy decision under Medicare secondary payer (MSP) laws when the Medicare member is <65 and entitled to Medicare based solely on end stage renal disease (ESRD).



Call Your Account Service Representative for More Information on This Subject

#### Dual Medicare Entitlement

Dual Medicare entitlement means that a person is entitled to Medicare based on ESRD and Age 65, or, based on ESRD and Disability. The ESRD entitlement can precede the Age 65/Disability entitlement or the Age 65/Disability entitlement can precede the ESRD entitlement.

If Medicare is the member's legal primary payer when dual entitlement becomes effective, Medicare remains the member's primary payer. Otherwise, the employer's plan remains primary payer during the first 30 months of the member's ESRD Medicare coverage.

#### For Members Enrolled in an Employer's Group Health Plan

A. When the ESRD entitlement precedes the Age 65/Disability entitlement and the Age 65/Disability Medicare effective date is within the first 30 months of the member's ESRD Medicare effective date then the employer's plan remains primary payer until the end of the 30-month period. Thereafter, Medicare becomes and remains primary payer for as long as the member remains dual Medicare entitled.

**Example:** ESRD Medicare is effective June 1, 2004. Age 65/Disability Medicare is effective February 1, 2005. **Result:** Employer's plan is primary until November 30, 2006. Medicare is primary December 1, 2006, and remains so thereafter.

B. When the ESRD entitlement precedes the Age 65/Disability entitlement but the Age 65/Disability Medicare effective date is after the first 30 months of the member's ESRD Medicare effective date then Medicare remains primary payer for as long as the member remains dual Medicare entitled.

**Example:** ESRD Medicare is effective September 1, 2001. Age 65/Disability Medicare is effective May 1, 2004. **Result:** Medicare is primary from March 1, 2004. Medicare remains primary.

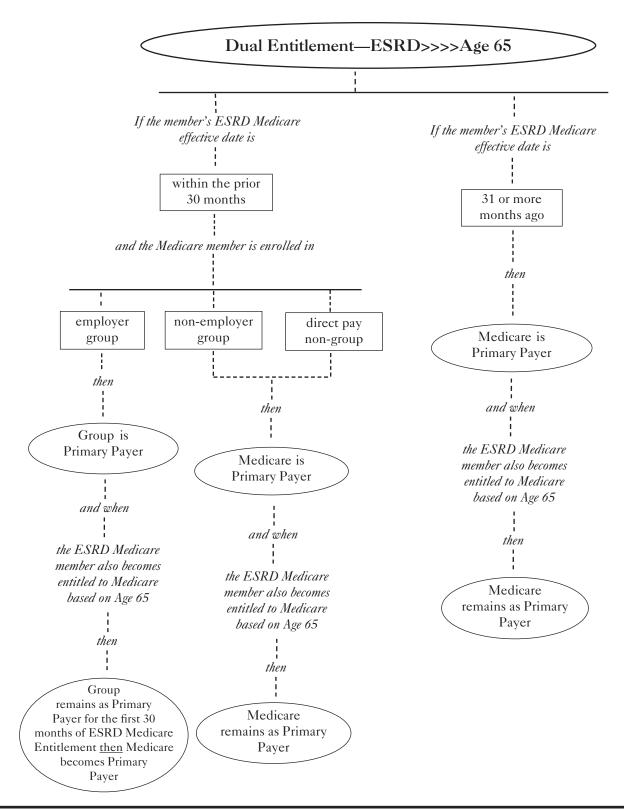
C. When the Age 65/Disability entitlement precedes the ESRD entitlement and the employer's plan is primary payer under the Working Aged (TEFRA) or Disability law then the employer's plan remains primary payer during the first 30 months of the ESRD coverage period. Thereafter, Medicare becomes and remains primary payer for as long as the member remains dual Medicare entitled.

**Example:** Age 65/Disability Medicare is effective June 1, 2000. ESRD Medicare is effective February 1, 2001. Employer has 20+/100+ employees and the Medicare member is an active employee or a dependent of an active employee. **Result:** Employer's plan remains primary until July 31, 2003. Medicare becomes primary August 1, 2003, and remains so thereafter.

D. When the Age 65/Disability entitlement precedes the ESRD entitlement but Medicare is primary payer under the Working Aged or Disability law then Medicare remains primary payer for as long as the member remains dual Medicare entitled.

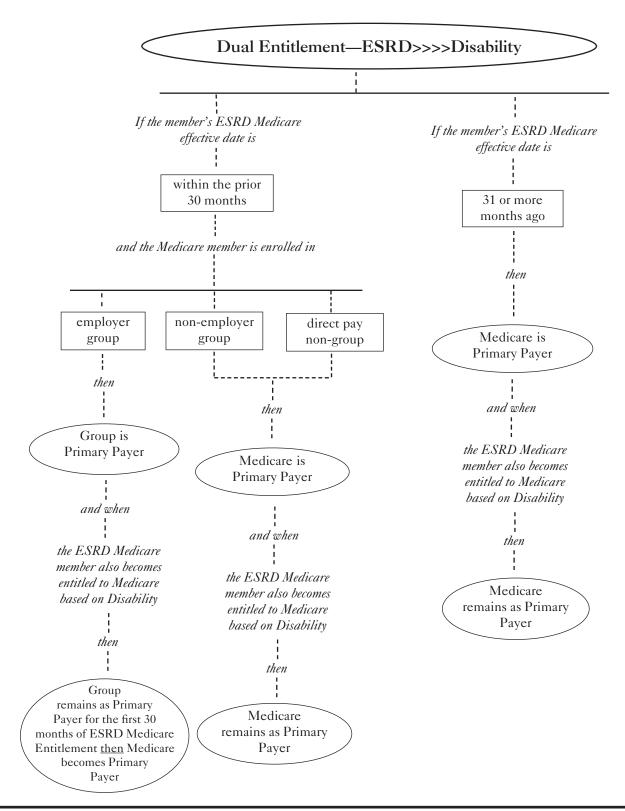
**Example:** Age 65/Disability Medicare is effective June 1, 2006. ESRD Medicare is effective February 1, 2007. Employer has <20/<100 employees or Medicare member is an inactive/retired employee or dependent of an inactive/retired employee. **Result:** Medicare became primary payer June 1, 2006. Medicare remains primary payer.

Primacy decision under Medicare secondary payer (MSP) laws when the Medicare member is <65 and entitled to Medicare based initially on end stage renal disease (ESRD) and then reaches age 65.

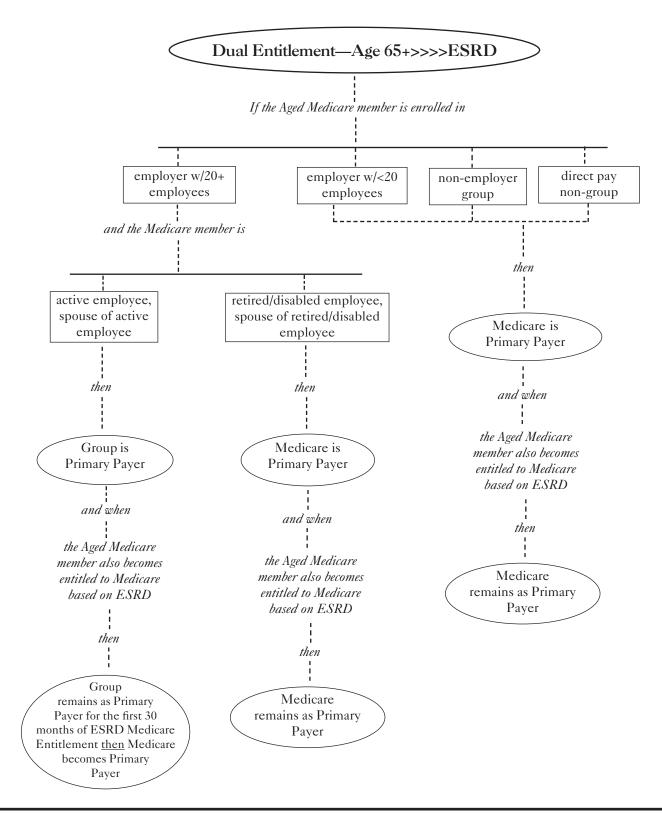


Call Your Account Service Representative for More Information on This Subject

Primacy decision under Medicare secondary payer (MSP) laws when the Medicare member is <65 and entitled to Medicare based initially on end stage renal disease (ESRD) and then on disability.

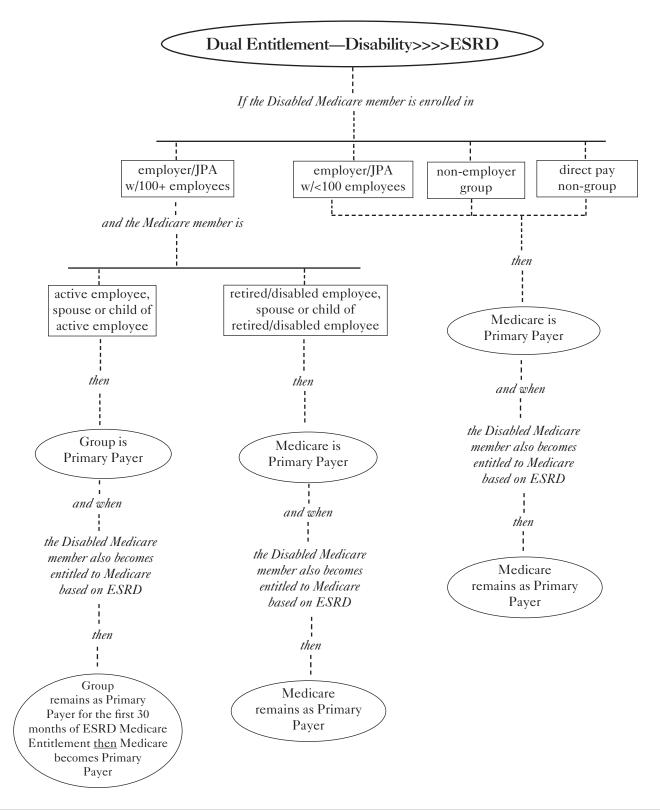


Primacy decision under Medicare secondary payer (MSP) laws when the Medicare member is 65+ and entitled to Medicare based initially on age and then on ESRD.



Call Your Account Service Representative for More Information on This Subject

Primacy decision under Medicare secondary payer (MSP) laws when the Medicare member is 65+ and entitled to Medicare based initially on a disability and then on ESRD.



Call Your Account Service Representative for More Information on This Subject

For companies with 20 or more employees, this is an example of how to complete the Enrollment and Change Form when a subscriber (age 65) is terminating group health coverage and transferring to non-group Medex.

ue Cross Blue Shield of M		B	Please PRINT	d The Instruction ing Out This Form						d Change Form North Quincy, MA 02171-914
censee of the Blue Cross	and Blue Shield Association	n	of black ink t	to avoid coverage delay.					-	
Company Name	1 1 1	0.	10.1		Curr	ent Medical		0		oup # Transferring To
P	100 0	ompa	ny		0					00000
Current BCBS ID N 99999 Type of Transacti	99999	Requested Effe	200.	MM DD	m		nt Dental Gr			tal Group # Transferring To
		digit termination code.	)	narks: (i.e., qualifying e	65-1	rans	ster	40 1	Mea	lex
CHANGE CHANGE CANCEL	R			Open Enrollment New Hire COBRA	Change to Family Add Spouse		Loss of C (HIPAA Con	Coverage atinuation of Co	verage Lette	er Required)
	out Yourself (N	Member 1)	_							
What products greyou selecting?	HMO Blue Network Blue Blue Choice Saver Product	Dental Blue Access Blue PPO	Blue	O Blue New England choice New England er (Write Name of Plan)			ĕ ¥	ind of Members Aedical) Individual Family	hip	Kind of Membership (Dental) Individual Family
Your First Name				M.I. Last Name	n D I	-			Sex	Date of Birth 06 01 1942
Street Address /PO	Bess		LAP		TTL	E		State A Zip C	JV/	MM DD YYYY
401	Park	Drive	^^^	13	oston	U-P-1	/	VIA	022	15
Social Security #		(617) 555	-000				urance Com	pany Name		City/State
PCP ID #: (see in	nstructions)		Name of	PCP		City/State				this your current PCP? lark X, if yes.
Are you Covered by Medicare? •	Part A Effective Da		Effective Da	1	Effective Date	Med	dicare to o	00000	\$	ctively Working
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Social Security #		Telephone # (area code)	)	Other Insurance	?• Other	Health Insu	urance Com	pany Name		City/State
PCP ID #: (see in	nstructions)	( )	Name of	PCP		City/State			ls	this your current PCP?
Martin 2										
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**Important note:** Please review forms carefully before submitting. Be sure to describe the requested transaction in the Remarks section.

#### Employees or Dependents Attaining Age 65 Report

This report will help you manage the nearing-65 process and help you comply with the requirements of Medicare Secondary Payer legislation.

This is the type of contract the member is covered under currently. Pay close attention to this because it can signal a number of action steps you may need to take, like canceling the membership if it's individual and the subscriber is turning 65; transferring the member into a retiree or Working Aged (TEFRA) group, or into a direct-pay Medex plan; or converting a family membership to an individual one to continue to cover an under-age-65 spouse or dependent. This potential cancellation date is generally three months in the future. At this point, the member is not yet cancelled but probably needs to have the membership adjusted to coincide with his or her Medicare eligibility. Remember, we determine the cancellation date based on the Medicare eligibility date, which is the first day of the month in which the member turns 65 (unless the birthday falls on the first day of the month—then Medicare is effective on the first day of the previous month).

	<u>_</u>	/	/ The same
	\		Y
			member may
BlueCross BlueShield			appear on up to
of Massachusetts	$\backslash$		three monthly
			reports. The first
	ATTAINING AGE 65	PAGE: MONTH ENDING:03/31/00	time, the report
REPORT ROUP-BU: 006007771-0000	$\backslash$	CBU:	will show "1st ag
GROUP NAME: ABCLEANING SE	RVICES	CCOUNT NUMBER: 400001/	65 letter." The
MEMBER IDENTIFICATION	DATE OF TYPE	OF CANCEL	second time, it
ADDRESS/PHONE RELATION NUMBER	BIRTH CONTR.		will show "2nd
PHILIP BARRY SUBSCRIBER 0123158740000	00 07/12/30 127-FAMIL	Y 07/01/00 1ST AGE 65 LTR	age 65 letter." The third time,
101 PORTER ST E.BOSTON MA 02113-1311			it will show
(617) 325-1291			"canceled—no
TERRI M CHURCH SPOUSE 0111431370000 857 CAMBRIDGE ST	01 07/13/30 127-FAMIL	Y 07/01/00 1ST AGE 65 LTR	letter" to indicate
CAMBRIDGE MA 02117-1214			that the actual
(617) 325-1291			cancellation
STEVEN HANKS SUBSCRIBER 0124128540000 256 LYNN TERRACE DRIVE	00 07/12/30 119-FAMIL	Y 07/01/00 1ST AGE 65 LTR	has taken place,
BROOKLINE MA 02137 (617) 326-6914			but no letter was
			mailed
BEVERLY B MASON SUBSCRIBER 0114517670000 748 SHAWMUT AVE	00 07/12/30 111-FAMIL	Y 07/01/00 1ST AGE 65 LTR	maned.
BOSTON MA 02116 (617) 482-1985			
RICHARD P SNOW SUBSCRIBER 0124582720000	00 07/12/30 101-FAMIL	Y 07/01/00 1ST AGE 65 LTR	
863 SUNNY DRIVE	00 07/12/50 101-FAMIL	I UT/UT/UU IST AGE 65 LTR	
NATICK MA 02267-0121 (508) 623-1584			
KATHERINE M GILL SPOUSE 0110621250000	01 05/15/30 127-FAMIL	Y 05/01/00 2ND AGE 65 LTR	
1600 HANCOCK ST QUINCY MA 02167			
(617) 847-3125			
PAUL J JONES SPOUSE 0121067110000	01 05/12/30 111-FAMIL	Y 05/01/00 2ND AGE 65 LTR	
311 MAIN ST CAMBRIDGE MA 02138			
(617) 361-2184			
CHARLES SMITH SUBSCRIBER 0111741330000	00 05/12/30 111-FAMIL	Y 05/01/00 2ND AGE 65 LTR	
610 SLEEPER ST S BOSTON MA 02112-1211			
			1

**Please note:** If at any time during the three months the appropriate action is taken to change the member's status, the member will not appear on subsequent reports. Also, members in our managed care plans will only receive one letter and will not be automatically canceled. This is because our managed care Subscriber Certificates allow members to remain in the regular group beyond age 65. With respect to your employees age 65 or older who are retiring, we encourage you to advise your managed care members eligible for Medicare to consider a Medicare supplement plan to ensure that Medicare is the primary payer rather than your managed care plan. Moreover, if you, as an employer, are not subject to the Federal Working Aged TEFRA Regulations because you have less than 20 active employees, all active and retired members and their spouses should be transferred to a Medicare supplement plan when they reach age 65. If, however, you are subject to the Federal Working Aged TEFRA Regulations, then you must advise your age-65 actively working employees and spouses that your group health plan or Medicare may be selected as the primary payer and that a new selection may be made each contract year. With respect to this latter group, you may not in any way influence selection of the primary payer of an employee or spouse, but rather must provide sufficient information about coverage and costs to help the individual make an informed decision.



## Other Party Liability

Other Party Liability (OPL) is a cost-containment program designed to avoid payments when another party is responsible for payment.

To ensure coordination of benefits, employees must tell us about other health plans they may have at the time of their initial enrollment or when requested by Blue Cross Blue Shield of Massachusetts.

#### **OTHER PARTY LIABILITY**

Primary and Secondary Coverage	In general, when a member has dual or multiple coverage, we follow Coordination of Benefits (COB) guidelines determined by the Massachusetts Code of Regulations to decide which plan is primary (first payer) and which plan is secondary (second payer). Other insurance plans or coverage include: personal injury insurance; automobile insurance; homeowner's insurance; or other insurance policies or health benefit plans that cover hospital or medical expenses. You must include information on your enrollment forms about other health insurance plans under which you are covered. The guidelines follow.	
	1. The insurance plan or other coverage that does not have a COB provision in its provisions or is otherwise obligated under the law is always primary.	
	2. The subscriber's health care plan is primary when the subscriber is a patient. When the subscriber's spouse has his or her own health care coverage and is the patient, the spouse's coverage is primary. The subscriber's coverage of the spouse is secondary.	
	3. The health care plan of the parent whose birthday falls earlier in the calendar year (month/day) is primary for dependent children.	
	4. When guidelines 1 and 2 do not determine the order of liability, the health care plan that has covered the patient for the longer period is primary. The health care plan that has covered the patient for the shorter period is secondary.	
	5. When we receive a claim from a member who has primary health care coverage with another plan, we reject the claim and instruct the provider to submit it to the primary health care plan. We then consider any balance if our health care plan requirements have been met.	
No Fault	Most residents of Massachusetts carry coverage on their automobiles for medical bills, lost wages, and funeral expenses. This coverage is called Personal Injury Protection (PIP). PIP generally covers the first \$2,000 in medical expenses. After \$2,000 in PIP ha been paid, the employer's plan may become the responsible payer for medical bills onl	
Subrogation	Subrogation is the legal remedy that allows health care plans to seek reimbursement when a member is injured and there is third-party liability, such as in the case of a motor vehicle accident. We may pursue recovery if we determine that the member may receive a monetary settlement or award from the liable party.	
	Members are contractually obligated to inform us if they are involved in an accident or have been injured due to the act or omission of a third party. For certain diagnoses, forms are automatically sent to the member asking for information about the accident or injury.	
	Recovery may be pursued when there is third-party liability by proceeding under the Employee Retirement Income Security Act of 1974 (ERISA) or by establishing a statutory lien under General Laws c. 111, sec. 70A. Members are obligated to provide all requested information that is necessary to establish a claim or statutory lien.	

#### **OTHER PARTY LIABILITY**

Workers' Compensation	When a member suffers a work-related injury or illness, all medical claims related to that injury must be billed to your Workers' Compensation carrier. We may also pursue recovery against disputed work-related cases under General Laws c. 152, sec. 46A.	
Medicare	See Section 7, When a Member Becomes Eligible for Medicare.	
Annual Survey Process	To facilitate the Coordination of Benefits process, an annual survey will be conducted. The survey will be sent once a year to subscribers in the month of the subscriber's birthday. The form will ask specific questions regarding other health insurance. (See below for sample survey.) The toll-free telephone number is <b>1-888-799-1888</b> .	

	COORDINATION OF BENEFITS ANNUAL UPDATE
<b>1</b>	
MASSACHUSETTS	
P. O. Box 9213 N. Quincy, MA 02171-9907	
	ID #:
Dear	
making duplicate payments the information on our sys exceed 100% of the allow For these reasons, we ask of this letter. For your convenience, we	efits with the other carriers. This is done for a number of reasons: to avoid s to providers, to contain costs, avoid delays in claims processing because stem is not current, and to ensure that payments from all sources do not vable expenses. Coordinating benefits allows BCBSMA to control costs. It that you take a few moments to answer the questions on the reverse side <b>encourage you to use our dedicated toll-free telephone line, 1-888-</b> response to the questions. An envelope is also enclosed if you prefer to ting.
	responding to the questionnaire and assisting Blue Cross and Blue Shield orts to provide you and your family with high quality services.
Sincerely,	
Lena Reddick, COB Manag Other Party Liability Departr	
Please complete th	he questionnaire on the reverse side of this letter. Thank you.

Call Your Account Service Representative for More Information on This Subject

#### **OTHER PARTY LIABILITY**

Annual Survey	
Process (continued)	1. During the past two years, has <u>anyone covered under the ID number shown on</u> <u>the reverse side had other</u> <b>medical or dental</b> insurance or Medicare coverage along with BCBSMA? Yes No
	If NO, simply call us at 1-800-882-1615 during normal business hours Monday through Friday between 8 AM and 5 PM. If YES, proceed to question 2 with other medical or dental insurance details; or, to question 3 if Medicare is involved. You may then call us directly between the hours of 8 AM and 5 PM Monday through Friday at 1-800-882-1615 or sign this form and mail your response to us in the enclosed return envelope.
	2. Name of the person carrying the other insurance:
	Other insurance telephone number:
	Other Policy/ID number:
	Effective and/or Termination Date of Other Coverage:
	Employer through which the coverage is offered:
	<ul> <li>3. Medicare details:</li> <li>As the subscriber/policyholder of this contract, select one of the following that best describes your status with the group through which you have your BCBSMA insurance coverage: <ul> <li>Actively Employed</li> <li>Spouse or Divorced Spouse of an Active Employee</li> <li>Disabled or Retired Employee</li> <li>Disabled or Retired Employee of a Disabled or Retired Employee</li> <li>Widow or Widower of a Former Employee</li> <li>COBRA</li> <li>Other, please explain:</li> </ul></li></ul>
	<ul> <li>Name of the Medicare Recipient:</li></ul>
	Subscriber's Signature: Date://
	040302 VERS1

Please note: This process became effective April 1, 2001.



## Account Billing and Premium Information

#### **ACCOUNT BILLING AND PREMIUM INFORMATION**

<b>Overview</b>	Under fully insured billing, you pay us a monthly fee based on a rate determined by our Underwriting Department. We issue invoices monthly, which reflect all membership transactions and payments since your last invoice.	
Invoices We'll Send You	We base your invoice on the determined rate (individual, family, etc.) multiplied by the number of subscribers. The amount may fluctuate based on the number of enrollees and other activity that occurs within the billing period. You'll receive a separate monthly invoice for each group number assigned to your account 20 days prior to the due date.	
Payment Guidelines	We offer our premium customers the option of six different due dates: the 1st, 5th, 10th, 15th, 20th, and 25th of each month. To ensure claim payment, we require your payments on or before the due date. You must pay as billed. Short-paying invoices in anticipation of enrollment credits is not allowed. Doing so may result in cancellation of your coverage for non-payment. Please wait for enrollment credits to appear on your invoice. We offer the following payment options:	
	1. Electronic funds transfer (EFT), which allows you to wire the money directly into our account on the due date.	
	2. Debit/Credit ACH, which allows us to debit or credit the money to/from your bank account on the due date.	
	3. Check. Please be sure to write your account number on your check and include the remittance portion of your invoice. Remember to allow sufficient time for mailing so that we receive your payment on or before the due date.	
	The Attorney General has issued regulations for cancellation of Group Health Insurance. You and your employees will be affected only if you do not pay your health insurance bill by the due date. The regulations require us to mail letters to subscribers telling them that their health insurance is being canceled because their employer did not pay their bill. Because the regulations require us to honor all claims for services members receive before they receive our termination notice, we will be mailing notices three days prior to the anticipated cancellation date.	
	We'll provide a return envelope with your monthly invoice, which is for <b>payments onl</b> y. Please remit payments to this address:	
	Blue Cross Blue Shield of Massachusetts P.O. Box 4701 Woburn, MA 01888-4701	

#### ACCOUNT BILLING AND PREMIUM INFORMATION

If you have a written inquiry about your invoice, please direct it to your Customer Receivables Management Analyst at this address:

Blue Cross Blue Shield of Massachusetts Customer Receivables Management Landmark Center 401 Park Drive, Mail Stop 01/07 Boston, MA 02215-3326

Do not enclose correspondence or enrollment requests with your payment. This will cause a significant delay in processing your request.

If you have an enrollment inquiry, please contact your Account Service Representative.

#### If you need Assistance

If you have questions about your invoice, please call **1-617-246-5841**. A Customer Receivables Management Analyst can help you weekdays, 8:30 a.m. to 4:30 p.m.

eBill provides accounts total control over the management of their health care premiums. eBill will allow employers the ability to:

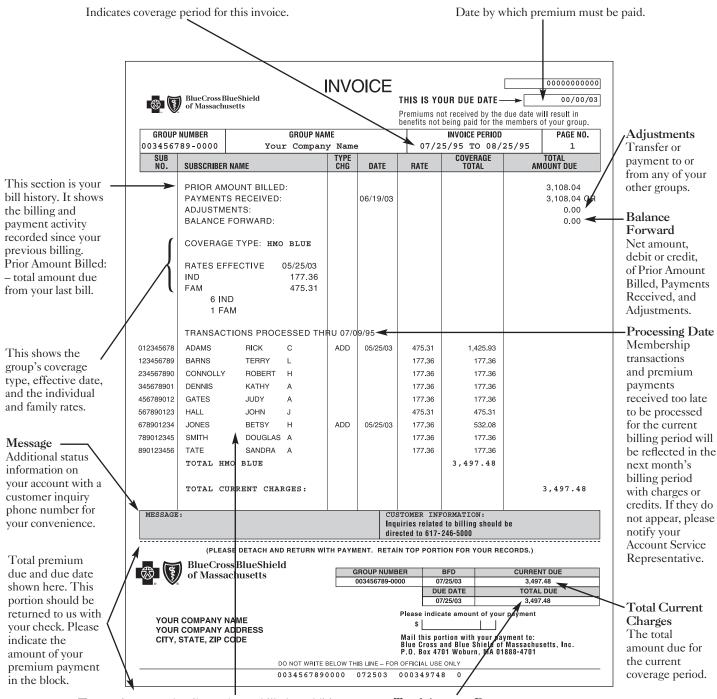
- View and manage their invoices from one location
- Control how invoices are paid through our secure, online portal
- Get convenient, advance notification of new invoices via e-mail
- Download reports to track health care bills and payments

eBill is expected to be available to accounts during the summer of 2007. In addition, it will only be available to accounts that have a fully insured, premium-based financial arrangement (does not include self-insured accounts).

eBill

#### ACCOUNT BILLING AND PREMIUM INFORMATION

This is an example of a Premium Invoice.



Transactions are subscribers who are billed as additions, removals, or changes to the membership roster for your group. There is an explanation of each membership transaction, the effective date, and the monthly rate. The amount billed for additions and changes includes premium for the current billing period and all retroactive months.

#### Total Amount Due

Your check should pay the total amount due. If you sent last month's premium too late for it to appear as a credit on this month's statement, you may deduct this payment from the total amount due and indicate the amount you are paying on the bottom portion of your bill.

Do not enclose enrollment requests with your monthly payment (for example, do not mark removals on bill).

Call Your Account Service Representative for More Information on This Subject



## Submitting a Claim

#### **SUBMITTING A CLAIM**

Under most plans, members do not need to submit claim forms. Participating providers within Massachusetts and providers that have an agreement with the local Blue Cross and/or Blue Shield plan are contractually required to submit claims for most services directly to us.

There are some times when members need to submit their own claim forms for reimbursement, such as for emergency services received while traveling. Please refer to your plan description for more information on this.

When members are required to submit their own claims, they should send the completed claim forms, along with itemized bills, directly to us. The claim submission address is on the claim form. The itemized bill must contain the following information:

- Employee's name
- Name of the patient
- Date of service
- Type of service, with the corresponding charge
- Diagnosis

**Please note:** The submitted bill must be on the provider's letterhead or signed by the provider. Bills from outside the United States must be translated into English, and the provider charge must be shown in American currency.

You may request a supply of claim forms from your Account Service Representative, or your employees may call Member Service to request claim forms.

If a member has a question about the payment or denial of a claim, please refer to your plan description for more information on the claim review and appeals process.



## Contract Renewal

#### **CONTRACT RENEWAL**

#### Account Agreement and Contract Renewal Rates

When it's time to renew your contract, your account executive is available to review your financial program and your contract terms. You will receive new rates prior to your contract's renewal date.

#### **Plan Sponsor Responsibilities**

- Review your renewal rates and account agreement with your account executive; have the authorized party sign and return the contract, if required.
- If you do not wish to renew, please inform us, in writing, at least 30 days before your contract renewal date.

Open Enrollment Periods and Blue Cross Blue Shield of Massachusetts Presentations During your annual open enrollment period, Blue Cross Blue Shield of Massachusetts is available to help you design a special presentation that provides valuable plan information—not only for employees considering plans that are insured or administered by Blue Cross Blue Shield of Massachusetts, but also for current members. Your account executive will assist you in planning and scheduling a special enrollment presentation. He or she will work with you to meet your group's specific needs.

#### Call Your Account Service Representative for More Information on This Subject



### Health Insurance Portability and Accountability Act of 1996 (HIPAA)

#### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Background	The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is one of the most significant federal laws affecting the regulation of health care benefits in history. The purpose of this piece of legislation was to address portability, access, nondiscrimination, and enrollment requirements for all group and individual health plans. Generally, most of the compliance was to begin on June 1, 1997.
Portability	HIPAA restricts pre-existing condition limitations. Such limitations:
Rule	• cannot last more than 12 months (18 months for late enrollees),
	• must be reduced by prior creditable coverage,
	• cannot be applied to newborns or newly adopted children if they are enrolled within 60 days, and
	• cannot be applied to pregnancy.
	These restrictions are unlikely to affect Blue Cross Blue Shield of Massachusetts plans since we do not generally place pre-existing condition limitations on any of our products.
Creditable Coverage	Creditable coverage is defined as most-recent previous coverage, including COBRA coverage.
Creditable Coverage Certificates	The group health plan (employer or trust) and/or insurer are obligated to provide a certificate documenting the creditable coverage both when a member loses coverage, and again when a member loses COBRA coverage. This certificate is used to demonstrate previous creditable coverage to reduce or eliminate pre-existing conditions with a new employer or carrier (see page 12-3). Blue Cross Blue Shield of Massachusetts will provide all members with a certificate of coverage, unless otherwise requested by the account. Please notify your Account Service Representative should you wish to send certificates of coverage to your terminated members. Members are also entitled to receive a certificate when his or her claim is denied because the lifetime maximum is exhausted.
Discrimination Prevention	HIPAA prohibits limitation on enrollment or continued enrollment based upon health status, a specific medical condition, medical history, claims history, genetic information, evidence of insurability, or disability.
Enrollment Requirements for Small Group Market	HIPAA requires the availability of small group and individual market health insurance products.

How to Get More<br/>HIPAA InformationThe U.S. Department of Labor provides additional information about HIPAA.<br/>You can call the Employee Benefits Security Administration Hotline at<br/>1-866-444-EBSA (3272). You can also access more information online at:<br/>http://www.dol.gov/ebsa/publications/yhphipaa.html and<br/>http://www.dol.gov/ebsa/pdf/CAGTableOfContents.pdf

#### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

1	
	(1)
1	
	BlueCross
	BlueShield
	of Massachusetts

One Enterprise Drive Quincy, MA 02171-2126 Certificate of Group Health Plan Covera

1. Date of this certificate: MM/DD/YY	2. Name of group health plan: NAME OF GROUP INSURANCE PLAN
3. Name and Address of participant: >00001 1234567 001 08156 SUBSCRIBER NAME ADDRESS LINE 1 ADDRESS LINE 2 CITY/STATE/ZIP	4. Identification number of participant: XXXXX9999
5. Name of individuals to whom this certificate applies:	6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:
SSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSSS	Blue Cross Blue Shield of Massachusetts Coverage Certification Unit P.O. Box 9145 Quincy, MA 02171
00000000000000000000000000000000000000	To speak with a Representative, call the Member Servic telephone number listed on the front of your ID card.
7. For further information, call: Please contact the plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.	8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), write Yes and skip lines 9 and 10: Yes or No; Yes
9. Date waiting period or affiliation period (if any) began: For waiting period information, contact the plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.	10. Date coverage began: MM/DD/YY
11. Date coverage ended (or if coverage has not ended, enter "continuing"): MM/DD/YY	[Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.]

#### **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.

<u>Preexisting condition exclusions</u>. 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 exclusion 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 for 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.

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#### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

P Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

<u>Right to get special enrollment in another plan</u>. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

P Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

<u>Prohibition against discrimination based on a health factor</u>. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

<u>Right to individual health coverage</u>. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- ✓ Your most recent coverage was under a group health plan (which can be shown by this certificate);
- ✓ You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <u>http://www.dol.gov/ebsa,</u> the DOL's interactive web pages - Health Elaws, or <u>http://www.cms.hhs.gov/hipaa1</u>

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Glossary

This glossary defines terms frequently used by Blue Cross Blue Shield of Massachusetts.

BlueLinks	An umbrella term for all Blue Cross Blue Shield of Massachusetts web-based tools.	
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986)	Federal legislation that provides for the continuation of coverage for members who would lose eligibility for group coverage as a result of a qualifying event. COBRA applies to companies that employ 20 or more eligible employees. Members pay a percent of premium during extension of coverage as a result of disability.	
Coordination of Benefits (COB)	Blue Cross Blue Shield of Massachusetts will coordinate payment of covered services with other hospital, medical, dental, or health care plans under which you are covered. Blue Cross Blue Shield of Massachusetts will do this to make sure that the cost of your health care services is not paid more than once. Other insurance plans and coverage include personal injury insurance, automobile insurance, homeowner's insurance, or other insurance policies or health benefit plans that cover hospital or medical expenses.	
DRG/Diagnostic Related Group	An inpatient reimbursement system based on certain claim data such as patient's diagnosis, surgical procedure, age, sex, and discharge status. Unlike traditional payment systems that are based on the number and cost of services provided and the number of days a patient spends in the hospital, the DRG system pays the hospital a fixed amount for cases in each DRG.	
eBill	A dynamic web-based tool used to manage premiums.	
Emergency Care	Medical, surgical, or psychiatric care that you need immediately due to the sudden onset of a condition manifesting itself by symptoms of sufficient severity, including severe pain, which are severe enough that the lack of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing your health or the health of another person (including an unborn child) in serious jeopardy, or serious impairment of bodily functions or serious dysfunction of any bodily organ or part or, as determined by a provider with knowledge of your condition, result in severe pain that cannot be managed without such care. Some examples of conditions that require emergency medical care are suspected heart attacks, strokes, poisoning, loss of consciousness, convulsions, and suicide attempts.	
Enrollment Area (applies to managed care plans)	The geographic area in which each member must be a permanent resident for coverage by the plan.	
FileLink		

Gatekeeper (applies to managed care plans)	Term applied to certain managed health care plans in which the primary care physician oversees and approves all medical care needs of patients.	
HMO/Health Maintenance Organization	An organization that provides or arranges for comprehensive care on a prepaid, fixed-fee basis. HMOs emphasize preventive and managed care to maintain the good health of their members, thereby controlling health care costs and preventing unnecessary use of health care services.	
Home Health Care	An extensive range of physician-prescribed professional, technical, and related medical care services provided in the member's home when medically necessary.	
Hospice Care	Benefits provided to terminally ill members who have agreed on a plan of care emphasizing pain control and symptom relief. Benefits include such services as home health care, drugs, continuous nursing services, respite care provided in a nursing facility, and bereavement services provided to the family or primary care person following the death of the hospice patient.	
Indemnity	A health insurance program that provides full or partial payment or reimbursement for various health care costs incurred by a covered member.	
Inpatient	Situation where a person is confined in a hospital as a registered bed patient; necessary services are provided on an inpatient basis, in contrast to an ambulatory basis. This also includes a patient who is receiving approved intensive services such as day treatment or partial hospital programs or covered residential care. (A patient who is kept overnight in a hospital solely for observation is not considered a registered inpatient.)	
Lifetime Maximum	The maximum benefit amount the plan will pay for a member while he or she is covered under a contract.	
Managed Care	An HMO or point-of-service plan that attempts to ensure cost-effective and quality health care through the use of a gatekeeper delivery system.	
Medicare	The federal hospital insurance system and the supplementary medical insurance program for the aged, created in 1965. Part A covers inpatient hospital services; Part B covers physician and outpatient department services. Part D covers prescription drugs.	
Member	A person eligible for health plan benefits either as a subscriber or as a covered dependent.	

Network	The group of providers affiliated with a certain health plan.	
PCP/Primary Care Physician (applies to managed care plans)	The physician responsible for a member's everyday health care needs, including diagnosis, treatment, and, when necessary, referrals. Members can select their own PCPs.	
Plan Sponsor	The plan sponsor is usually the same as the plan sponsor designated under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.	
POS (Point-of-Service)	A gatekeeper health care program that provides a higher level of coverage when the member uses health care services provided by a network provider. The member receives a lower level of coverage for health care services provided by a non-provider.	
PPO (Preferred Provider Organization)	A non-gatekeeper health care program that provides a higher level of coverage when the member uses health care services provided by a network provider. The member receives a lower level of coverage for health care services provided by a non-network provider.	
Preventive Care	Routine health care services that are provided in an attempt to detect health problems rather than treat them after they occur.	
Rider	An amendment to the plan that changes the terms of the subscriber's contract. A rider describes the material change that is made to the contract.	
SCP/Specialty Care Physician (applies to managed care plans)	Any managed care physician not classified as a primary care physician.	
Service Area (applies to managed care plans)	The area defined by the managed care plan as the geographic area in which services are rendered.	
SNF/Skilled Nursing Facility	A facility licensed as a skilled nursing facility. SNFs provide different levels of care, ranging from skilled nursing care and skilled rehabilitative care to custodial care. (Custodial care is not covered.)	
Subrogation	Subrogation is the legal remedy that allows the plan to be reimbursed when a member is injured and there is third-party liability, such as in a motor vehicle accident.	

**Subscriber** The person who signs the enrollment application at the time of initial enrollment for coverage.

#### Urgent Care (applies to managed care plans)

Medical, surgical, or psychiatric (mental health/substance abuse) care other than emergency care that the member needs to prevent serious deterioration of the member's health. For example, an unforeseen illness or injury occurs while the member is temporarily outside the plan's service area. In most cases, urgent care will consist of brief diagnostic and treatment services to stabilize the member's condition so that the member can return to the service area for treatment.



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