MASSACHUSETTS

PLAN SPONSOR MANUAL

May 2022

GETTING STARTED WITH BLUE

THANK YOU FOR CHOOSING BLUE CROSS BLUE SHIELD OF MASSACHUSETTS.

THIS MANUAL WILL HELP YOU ADMINISTER YOUR EMPLOYEE BENEFIT 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, contact your account service consultant. They'll make it easier for you and your employees to use your health and dental plans.

The information provided in this manual doesn't constitute legal advice. Regulations and procedures can change according to the law. Consult your attorney for individual advice.

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This manual will help you administer your employee benefit plan.

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Who Is Eligible for Coverage

This section doesn't apply to Medicare supplement plans. See "When a Member Becomes Eligible for Medicare" on page 29.

An employee is eligible for group coverage in an employer's group health plan when:

- There is an identifiable employer and employee relationship
- The employee earns income from the employer
- The employee claims that income according to state and federal income tax laws

The employee must also be:

- A permanent, full-time employee. This includes an owner, officer, or partner who regularly works 30 or more hours each week at the employer's usual place or places of business. The employer must pay and report the employee's wages in accordance with state and federal law.
- A permanent, part-time employee who regularly works at least 20 hours (but fewer than 30 hours) each week at the employer's place or places of business. The employer must pay a wage to the employee in accordance with federal and state law.

If your company has 20 or more employees, the actively working employees and their spouses—who are age 65 or older—must be enrolled in a non-Medicare supplement group plan. This happens only when your actively working employees (or their spouses) have chosen the group plan as their primary health care coverage.

If the employees or their 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 isn't 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 law (General Laws Chapter 32B, Section 2) 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) employee—and for whom eligibility isn't 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 your company's clearly defined and consistently administered retiree benefit plan

Please note that employees selecting a managed care plan must reside in the plan's enrollment area (see page 5).

For more information on active and retired employees age 65 or older, please see "When a Member Becomes Eligible for Medicare" on page 29.

When an Employee Is Eligible for Coverage (Employee Qualifying Events)

Initial Enrollment Policy

A member's initial eligibility is a qualifying event for the purpose 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
- 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)
- The employee involuntarily lost coverage under a spouse's group plan
- The employee involuntarily lost coverage under a nongroup plan
- The employee voluntarily canceled coverage under another health plan due to the total termination of an employer's contribution
- The employee acquired a new dependent due to marriage, birth, or adoption (adoption is subject to underwriting approval)
- The employee is required to provide health insurance for a dependent under a child support court order (child must be enrolled with the employee)
- The employee becomes eligible for premium assistance through a state Medicaid program or Children's Health Insurance Program (CHIP)
- The employee loses coverage under a state Medicaid program or CHIP

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), they may enroll as of the date the other coverage was canceled. Documentation in the form of a certificate of creditable coverage must include the following:

- Name of the prior employer and insurance carrier
- Member's identification number
- Enrollment and termination dates
- Reason for termination
- Names of all members covered under the plan

Documentation isn't required if the prior coverage was involuntarily lost and was offered or administered by Blue Cross Blue Shield of Massachusetts.

Internal Revenue Code–Section 125 Trust Plans

Some employers have established a Section 125 Trust plan (cafeteria plan) with the IRS that instructs 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. These include all of the Blue Cross Blue Shield of Massachusetts qualifying events as well as one we don't consider a qualifying event: a significant increase in cost or significant decrease in coverage under the member's current health plan.

If we receive an enrollment request that doesn't 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 aren't eligible to enroll in the employer's group health plan:

- A person who works for the employer
  - occasionally
  - as needed
  - at will
  - on a seasonal basis
  - who isn't defined as a permanent, regular employee
- A former employee who:
  - is no longer a permanent, regular employee
  - doesn't qualify as a disabled employee
  - doesn't qualify as a retired employee
  - doesn't qualify as a former employee entitled to continued coverage under state or federal law
- Corporate directors or trustees who aren't permanent, regular employees
- Friends, relatives, business associates, or any other persons who aren't permanent, regular employees
- Contractors, attorneys, consultants, accountants, and other associates who may or may not be paid for periodic services by the employer or who aren't permanent, regular employees
- Any dependent of any of the above person(s)
- Any person who doesn't qualify as a dependent of an enrolled member
- Any dependent of an employee who is eligible to enroll, but isn't enrolled in a group health plan
- Any person who isn't eligible to be a member as stated in the plan description and rider(s) that describe the employer's health care plan

How to Enroll Employees

To enroll employees in a health plan, we ask that requests be made through Electronic Enrollment EDI file, Electronic Self Service tool, or BluesEnroll. If you cannot send us an enrollment request through Electronic Enrollment EDI file, Electronic Self Service tool, or BluesEnroll, we require the request in writing. For security and confidentiality reasons, we prefer that written enrollment requests be sent to us by mail (U.S. mail or other private delivery service) or by fax. However, we'll accept written enrollment requests by email if you choose 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 not, the employee isn't eligible to enroll until your next Open Enrollment period.

Don't 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):

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

Additions: Requests to add a member 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 date with the following exception: for a dependent that has the qualifying event of becoming eligible for premium assistance under a state Medicaid program or CHIP or that loses coverage under one of these programs, the request to add the dependent must be received by us within 90 days of the requested date. 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 on the date of a member's qualifying event for the group transfer or as of the employer's Open Enrollment date. We must receive the transfer request 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 one of the employer's plans 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: We may reinstate members whose coverage has been terminated either in error or for not paying their premium. Their coverage will be reinstated on the date it was terminated when the:

- Period of reinstatement is less than four months
- Reason for termination wasn't voluntary or due to the transfer to another group plan
- Member hasn't been reinstated more than once in the past three years

Please put your request in writing and send it to your account service consultant.

Exception Enrollment Procedures

Send any requests for exceptions to our eligibility and enrollment policies and procedures to your account service consultant. Our Member Underwriting department will review your request. 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—must complete the Enrollment and Change form in full.

Please note that all eligible members must list their legal name as validated by their government-issued identification (i.e., Social Security card, birth certificate, or passport).

After your employees complete 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 employer.
- Mail applications to:

  Enrollment Department
  Blue Cross Blue Shield of Massachusetts
  P.O. Box 986001
  Boston, MA 02298-6001

- Fax applications to:

  1-617-246-7531

See pages 57-66 of the appendix for more details on how to fill out the Enrollment and Change form.

Electronic Enrollment EDI File

Electronic Enrollment EDI file is how we systematically take in data from your payroll or HR system, compare it to our enrollment eligibility database, and make the appropriate changes, if needed.

Our upgraded electronic platform requires submitters to send us the standard HIPAA 5010 834 format. These updates to our electronic processing improved the efficiency and accuracy of member enrollment and eligibility with:

- Increased data processing speed for each file, and fewer errors due to manual input
- A continuous audit of files to quickly identify and alert users to discrepancies
- Improved tracking and reporting capabilities
- Support for daily file uploads

Please note:
If you have any questions for your assigned electronic enrollment specialist and/or auditor, please email our Electronic Enrollment Team at **ElectronicEnrollment.Support@bcbsma.com**, and "cc" your assigned specialist or auditor. This will ensure that if they're out of the office, a back-up contact will be able to assist you. If there's an access to care issue, be sure to put "Access to Care" or "ATC" in the subject line.

Electronic Self-Service Tool

Our new Electronic Self-Service tool makes data entry and file processing easier for accounts and brokers that submit files electronically. All transactions performed on the tool must be included on your electronic file. If there's an access-to-care issue, you can use the self-service tool to:

- Add subscribers and dependents
- Update subscriber information
- Cancel coverage
- Request new ID cards
- Update members' doctor information

Employer Portal

The Employer Portal is an online resource that enhances employers' business relationships and operations with Blue Cross Blue Shield of Massachusetts.

The Employer Portal includes a comprehensive collection of additional resources to assist you in managing your health plan and responding to the needs of your employees. These resources include:

- **Forms & Documents:** This library includes downloadable forms (in Adobe Acrobat PDF format) to help you do business with Blue Cross Blue Shield of Massachusetts, such as the Fitness Benefit and member application forms.
- **Member Tools & Resources:** This section contains health care–related opportunities for you and your employees, such as cost management tools, plan and health management resources, provider selection tools, and value-added programs.
- **Manage Your Account:** In this section, you can access Enrollment Management, sign up for eBilling, take advantage of our employee engagement tools, and more.
- **Plans & Products:** This section contains resources and information about our full range of medical, dental, and ancillary coverage options.

BluesEnroll

BluesEnroll, our enhanced benefits enrollment tool, is offered in partnership with BenefitFocus, a leading provider of cloud-based benefit management services. BluesEnroll seamlessly coordinates the efforts of benefit administrators, employees, and brokers on a single platform.

You Can Do More with BluesEnroll

Accounts enrolling on BluesEnroll will benefit from many enhancements and features, including:

- Enhanced reporting—over 40 standard reports
- Employee access that enables them to enroll, select benefits, and make life-event changes
- Secure, online 24/7 access via desktop, laptop, or mobile
- COBRA administration
- Enforcement of employer business rules

Contact Information for Enrollment Questions

If you have questions about BluesEnroll, email **blue.enroll@bcbsma.com**.
If you're using the Enrollment Management tool, please call the Support Line at **1-800-650-9808**. or email **Enrollment.Helpdesk@bcbsma.com**.

These programs are available to accounts of a certain size. Please contact your account service consultant for more information about these products.

SECTION 3

ENROLLING DEPENDENTS IN A HEALTH PLAN

- Who Is Eligible for Coverage
- National Health Care Reform
- Massachusetts Health Care Reform
- How to Enroll Dependents
- Enrollment Underwriting
- Member Identification Cards and Numbers

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 or common-law spouse whose marriage is recognized as a legal marriage under the laws of the state in which the couple reside.
- Partner of a civil union if you have determined that such civil union partner is eligible for enrollment
- Domestic partner (covered by rider only)
- Dependent who is under age 26
- Dependent legally adopted[1]
- Dependent legal ward under guardianship
- Dependent under a child support court order[1]
- Disabled dependent child[1]
- Child of a covered dependent

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 (see page 14 for details). 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
- Date domestic partners sign an affidavit attesting to their relationship
- Child's date of birth, adoption,[1] or legal guardianship[1]
- Date of birth of a covered dependent's child
- Date the dependent child became eligible for premium assistance through a state Medicaid program or CHIP or lost coverage under one of those programs[1]
- Date specified in a child support court order[1]
- Date the spouse or child involuntarily lost coverage under another health plan[1]
- Date the spouse or child voluntarily canceled coverage under another health plan due to the termination of an employer's contribution[1]

Please be sure to review what is needed to add dependents, beginning on page 11.

Open Enrollment Eligibility Policy

Eligible employees and their eligible dependents who didn't enroll as of their initial eligibility date may enroll in the employer's group plan as of the employer's Open Enrollment effective date.

1. Additional documentation is required along with the enrollment application.

Newborn Dependent Children

Coverage for a newborn biological child becomes effective on the child's date of birth, provided the 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 isn't received within the time period allowed, we'll require an official record of birth, as recorded with the applicable state agency. (Hospital birth records aren't acceptable documentation.)

When the mother of the newborn is either the subscriber or dependent child enrolled on the policy, we don't require additional supporting documentation, provided that we have already recorded the mother's maternity claim for the birth on our claims system.

When the father of the newborn isn't named on the birth record, we'll accept results of laboratory paternity testing, or a letter from his attorney naming the father, or a court-issued judgment of paternity, or a court order naming the subscriber as the father of the child.

Children of 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 an explanation of the service area. Coverage for the dependent's child becomes available on their date of birth—only after we receive a completed employer's enrollment transaction request. You must submit this request in writing no more than 60 days after the child's birthday. We don't require any supporting documentation, provided that we have already recorded the mother's claim on our claims system. Otherwise, we require an official birth certificate. (Hospital birth records aren't 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, no foreign and U.S. adoption requests may be added without written approval of the Blue Cross Blue Shield of Massachusetts Member Underwriting department.

U.S. Adoptions

Children under age 26 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. We require signed verification from the licensed adoption agency identifying the child and verifying the date and basis of placement. Alternatively, we accept documents from state agencies or court documents.

The effective date of coverage for an adopted child who hasn't been previously living with the subscriber is the date of placement (for the purpose of adoption) in the subscriber's home. We require signed verification from the licensed adoption agency.

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

Foreign Adoptions

For foreign adoption, if the date of placement with the adopting parent(s) isn't noted in the adoption documentation from the official government papers translated into English, then a copy of the child's passport picture and a page showing a Department of Homeland Security, U.S. 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 consultant 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 (see pages 67-68 of the appendix for a sample of this 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'll 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 doctor.

State law allows disabled dependents to continue coverage under the parent's health insurance if certain eligibility and medical criteria are met. Review and approval, denial, certification, or 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.

Our 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. We also review medical records to determine the child's capability for engaging in self-supporting employment.

If we consider the child an eligible disabled dependent, then we'll determine to continue coverage on a permanent (for the duration of the condition or the parent's contract) or temporary basis. We recertify temporary disabled dependent status annually.

Make sure the subscriber submits a Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child form (see an example on pages 67-68 of the appendix).

Domestic Partners and Their Dependents

We provide coverage as a rider for domestic partners and their dependents 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 Member Underwriting department approval to confirm eligibility, where applicable, and proof of paternity or maternity.

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 court-ordered coverage must be terminated when:

- The employee is no longer eligible for the employer's group plan and is terminated from group coverage
- The child reaches the plan's maximum age limit

The court-ordered coverage can be terminated, if the employee voluntarily wishes to, in some circumstances. This may happen, for example, when:

- The employee has the court-ordered coverage through another comparable health plan
- The support order is no longer in effect

We'll allow the employee and child to enroll as of the date of notification at the account's request—if the employee isn't already enrolled in the employer's health plan.

However, this isn't 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 doesn't live within a reasonable distance from the service area, the child must be allowed to enroll in the plan. This situation doesn't create a qualifying event for the employee to transfer to another product or coverage. The employee may enroll in another of the employer's health plans 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 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.

Please 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 doesn't 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.

National Health Care Reform

On March 23, 2010, President Obama signed national health care reform into law. Many changes were made on or after September 23, 2010, for new sales and customers renewing their plan. Many of the advantages and requirements of national health care reform were already in place due to prior Massachusetts health care reform and other regulations. **Please note:** These guidelines may not apply to dental plans and grandfathered accounts. Please contact Account Service to determine if these guidelines apply for your account.

Dependent Coverage Extension to Age 26

Most group health plans and issuers offering group coverage or individual health insurance must offer coverage to all adult children up to the last day of the month in which they turn age 26—regardless of dependents' tax qualification status, marital status, student status, or employment status. This provision applies to all fully insured and self-insured medical accounts.

Prior to its anniversary date on or after January 1, 2014, a self-funded health plan that is grandfathered doesn't have to cover an adult child under age 26 if that adult child is eligible for coverage under an employer-sponsored plan (other than that of a parent).

Frequently Asked Questions About Dependents Under National Health Care Reform

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

Yes. Federal law requires health plans that provide dependent coverage for children to continue to make that coverage available up to the last day of the month in which they turn age 26.

Q: Who is included as an adult dependent under the new health care reform law?

Adult dependents are the adult children of individuals covered by a group or individual health plan. Under federal law, coverage must be granted to dependents up to the last day of the month in which they turn age 26, regardless of their tax filing status, marital status, or financial dependency on their parent. However, under federal law, coverage doesn't have to be granted to the spouse or child of a covered adult dependent.

Q: Does this law grant coverage to children under the age of 26 who aren't currently covered under an existing policy?

Plans effective on or after September 23, 2010, give dependents under the age of 26 eligibility for coverage under an existing policy.

Q: Does the law require adult dependents be dependents as defined by the IRS?

No. The regulation specifically states that this isn't required for dependents under this provision.

Q: Is the requirement up to age 26 or through age 26 (and to age 27)?

When companies do offer dependent coverage, the coverage must be offered to dependents up to the last day of the month in which they turn age 26.

Q: Does the law require adult dependents be full-time students?

No. The law contains no requirement that adult dependents under age 26 have student status in order to be eligible for coverage.

Q: Does the law require my company to offer dependent coverage?

No. The law doesn't require a company's health plans to cover dependents. The law only requires a plan that already provides coverage for dependents to provide it up to the last day of the month in which they turn age 26.

Q: If my company already offers coverage to adult dependents–up to age 26–does the law require us to provide coverage for them even when they are married?

Yes. As long as the group policy allows for dependent coverage, the company's health plans must continue to offer married dependents coverage up to the last day of the month in which they turn age 26. However, the law doesn't require that the group policy expand coverage to a spouse or child of the married dependent.

Q: Does the law require coverage for children of dependent children (i.e., grandchildren)?

No. The federal law doesn't require a company to make coverage available for a child of an adult dependent receiving dependent coverage. However, Massachusetts state law does require fully insured plans to provide coverage for dependents of dependents.

Q: Can my company apply a rate surcharge for new adult dependents?

No. The regulation prohibits health plans from varying the terms of coverage based on age. For example, your company wouldn't be able to impose a premium surcharge for children older than age 18.

Q: Does my company have to offer COBRA when adult dependents reach age 26?

Yes. The new law doesn't change COBRA requirements, and COBRA will apply to adult dependents when they're qualified beneficiaries (the same as it applies to any other qualified beneficiaries).

Q: Does an adult dependent under age 26 and on COBRA have the right to re-enroll based on their age?

Yes. An eligible dependent covered under COBRA must be given the opportunity to enroll as a dependent of an active employee. Also, in this situation, if the child loses eligibility for coverage due to a qualifying event (including aging out of coverage at age 26), the dependent has another opportunity to elect COBRA continuation coverage.

Massachusetts Health Care Reform–Updates on Dependent Eligibility

As of January 1, 2007, the following defines our standard eligibility on our insured plans for dependent coverage, including adoptive children and newborns:

- Eligibility extended to age 26—or for two calendar years after the dependent last qualified under Internal Revenue Code—whichever comes first

Student Dependent Children

Here we outline our policies for student dependent children under the age of 26.

A student dependent is a full-time student at an accredited educational institution.[2]

This includes:

- High school students
- College undergraduates with at least 12 credit hours per semester
- Graduate students with at least 12 credit hours per semester

The following students are eligible for coverage:

- Unmarried, full-time students who live with the subscriber or subscriber's spouse on a regular basis
- Student dependents on medical leave
- Student dependents who lose full-time status due to illness or injury

Coverage ends for student dependents when the first of the following list occurs:

- Student dependent turns 26 (last day of the month in which they turn 26)
- Student dependent marries
- November 1 after discontinuing full-time classes
- November 1 after graduation
- After being on medical leave for a year

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
- Disabled dependent children—dependent children who are mentally or physically unable to earn their own living and who are enrolled under the subscriber's plan. These children will continue to be covered after they would otherwise lose dependent eligibility.
- Newborn infants of enrolled dependents—from the moment of birth and continuing until the enrolled dependent is no longer eligible as a dependent

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

Frequently Asked Questions About Dependents Under Massachusetts Health Care Reform

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 won't continue our current student dependent certification process. To help ensure compliance, we'll instead send 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 or subscriber's eligibility and request documentation from the subscriber at that time.) See pages 69-70 of the appendix for an example of the Student and Dependent Eligiblity Report.

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

Yes. All fully insured, Massachusetts employers and their employees, regardless of where the employees live, are eligible for the updated dependent coverage. However, some plan provisions, such as HMO Blue, may limit the benefits a dependent can receive when they get care outside of the service area.

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

Although we expect employers to validate eligibility of all dependents prior to enrollment, we may audit accounts and request eligibility documentation. We 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 U.S. and foreign adoptions), see pages 12-13 and the following Enrollment Underwriting section for required documentation.

For disabled dependents over age 26, attach a Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child form (see a sample on pages 67-68 of the appendix).

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'll honor that date.

However, we won't process any request that is over 60 days retroactive without underwriting approval. Contact your account service consultant for details.

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

See pages 57-65 of the appendix for details on how to complete the Enrollment and Change form.

Enrollment Underwriting

What Do We Need to Enroll a New Dependent?

Completed applications received within 60 days of the 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 or dependent(s) due to loss of coverage—completed and signed application.

Newborn on a family plan—completed and signed application.

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

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

Dependent or spouse arriving in the country—completed and signed application, and copy of passport with date-of-entry stamp.

U.S. 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 U.S.-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: Our Member Underwriting department must approve applications we receive beyond 60 days from the requested effective date. We may also require additional information (e.g., marriage certificate, subscriber's signed and dated enrollment application, or birth certificate). Please contact your account service consultant for instructions.

Member Identification Cards and Numbers

Following enrollment, we send ID 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 or PPO plan**, we send ID cards to all enrolled family members. For family policies for other medical plans and for dental plans, we send out two ID cards with the subscriber's name.

The ID card includes an identification number with a three-letter prefix. The three-letter prefix identifies the type of plan the subscriber has selected.

If a member's ID card is lost or stolen, please contact your account service consultant for a replacement card. Alternatively, the member may call Member Service directly for a replacement card.

SECTION 4

CHANGING A MEMBER'S STATUS

There are times when a member who is enrolled in a health plan may need to change their membership status. Examples are name, address, and coverage changes. 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 Provider (PCP)

Changing Status

Changing Status on Paper

The Enrollment and Change form is used for some membership status changes. Some status changes, such as the birth of a dependent child, require a different form. The form can be downloaded from **employer.bluecrossma.com**. See the appendix for examples of how to make the certain changes, such as below.

You can make the following changes at any time:

- Name
- Address
- For managed care plans, the PCP may change anytime after enrollment
- Member becoming eligible for Medicare for reasons other than reaching the age of 65

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

- Marriage of the subscriber
- Civil union
- Divorce of the subscriber
- Birth, legal guardianship, or adoption of a dependent child
- A dependent child reaching the maximum age limit for coverage under a family contract
- Member becoming eligible for premium assistance through a state Medicaid program or Children's Health Insurance Program (CHIP)
- Member losing coverage under a state Medicaid program or CHIP
- A member reaching age 65
- Death of a member

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

Changing Status Electronically

- **Accounts**

To make updates to employee information, access BluesEnroll at **enrollment.bluecrossma.com**.

- **Employees**

To make updates to their information, employees must register on MyBlue at **bluecrossma.com** or access BluesEnroll at **enrollment.bluecrossma.com**.

See page 62 of the appendix for an example of how to change an address. You may also use this example for other types of changes to a member's information.

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. 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. Also, describe the type of dependent change in the **Remarks** section.

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

Transferring Coverage

An employee can transfer their membership from one Blue Cross Blue Shield of Massachusetts health plan to another Blue Cross Blue Shield of Massachusetts plan only during your Open Enrollment period.

A member in a managed care plan who moves outside the enrollment area **may** be eligible to transfer their coverage. Please consult with your account service consultant for more information.

See the example on page 63 of the appendix to learn how to transfer a subscriber from one group to another during Open Enrollment.

Terminating Coverage

Coverage for the subscribed **employee (and enrolled dependents)** ends at 12:01 a.m. on the cancellation date when:

- We terminate your account for nonpayment of premiums or changes.
- Your account doesn't renew the contract with Blue Cross Blue Shield of Massachusetts.
- The subscriber becomes ineligible for coverage by not meeting your account's or Blue Cross Blue Shield of Massachusetts' requirements.
- The subscriber (or a covered dependent) becomes ineligible for coverage as a result of misrepresentation or fraud.
- The subscriber (or covered dependent) misuses the Blue Cross Blue Shield of Massachusetts ID card to obtain coverage for which they aren't eligible for under an existing contract. Or, they misuse the ID card by letting another person not enrolled for coverage in that plan attempt to obtain coverage under the contract. Termination will be retroactive to the date of misrepresentation or fraud.
- The subscriber or dependent physically or verbally assaults network providers or other members—which is unrelated to their mental or physical condition. Termination will follow procedures approved by Massachusetts Commissioner of Insurance.
- The subscriber dies. (If the surviving dependents are eligible for continued coverage, a new enrollment request is required.)
- A Medicare-eligible subscriber reaches age 65 and retires (or is already retired). See "When a Member Becomes Eligible for Medicare" on page 29.
- The subscriber voluntarily ends coverage or leaves employment.

Coverage for a **former spouse** ends when:

- The divorced spouse becomes ineligible for coverage.

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

- The subscriber's coverage ends, as described above.
- The dependent child reaches the last day of the month in which they turn 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 "Enrolling Dependents in a Health Plan on page 10.

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 stated in your contract.

There is an example of a voluntary member termination on page 64 of the appendix—this example applies to other terminations as well.

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, Monday through Friday, 8:00 a.m. to 5:00 p.m. ET, or visit us at **bluecrossma.org/myblue/learn-and-save/plans-and-benefits/medical**.

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

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 the forms carefully before submitting.

How to Change a Primary Care Provider (PCP)

(Applies to managed care plans only)

To change a primary care provider, the employee and the employer complete the Enrollment and Change form and return it to the address on the form.

Please note: Members may also call Member Service at **1-800-821-1388** to make this change over the phone. Alternatively, the member may change their PCP online by signing in to MyBlue at **bluecrossma.org**.

- 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 or Network Blue®.
- The change will be effective on the day Blue Cross Blue Shield of Massachusetts 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 their new PCP for referrals for continued care.

See page 65 of the appendix for an example of the Enrollment and Change form that shows how to change a member's PCP.

SECTION 5

CONTINUATION OF COVERAGE

Continuation of coverage may be available as required by federal COBRA law, or similar Massachusetts law, known as Mini-COBRA. This section describes the COBRA and Mini-COBRA requirements, as well as nongroup options.

- COBRA
- Mini-COBRA
- Blue Cross Blue Shield of Massachusetts Nongroup Plans

COBRA

COBRA is an acronym for the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1986. COBRA requires group health plans to offer certain individuals (referred to as "qualified beneficiaries") continued coverage under the group health plan for a period of time at a cost to the qualified beneficiary. COBRA applies to individuals who would otherwise lose their group health plan coverage due to a qualifying event (such as employment termination).

Employers, including those with self-funded group health plans, who had at least 20 employees on half of the 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 had 20 or more employees.

If you're an employer subject to COBRA, you should speak with an attorney regarding your COBRA obligations.

Small Employers

Although health plans offered by small employers (employing fewer than 20 employees in the previous year) aren't subject to COBRA, they **are** subject to Mini-COBRA.

Mini-COBRA

Mini-COBRA requires continuation of group health coverage for employees in insured groups with 2–19 employees.

Frequently Asked Questions About Mini-COBRA

Q: Who is eligible for Mini-COBRA continuation of coverage provisions?

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 individuals become "qualified beneficiaries" who have 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, Blue Choice®, or Access Blue—and the qualified beneficiary moves outside the plan service area.

It's your responsibility to remind the qualified beneficiary that benefits are only available for emergency and urgent care services outside the plan service area.

Q: What is a qualifying event?

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

- Termination of employment (except for termination due to gross misconduct or reduction of work hours—e.g., employee begins a leave of absence or changes from full-time to part-time).

  This includes:

  – Voluntary resignation
  – Involuntary termination
  – Retirement
  – Layoff

- Death of the employee
- Divorce or legal separation[3]
- Loss of eligibility for a dependent child (e.g., over-age dependent student)
- Employee becomes eligible for Medicare
- Retiree (or surviving spouse of a deceased retiree and their dependent children) loses coverage due to their former employer's bankruptcy proceedings.[4] (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.)

3. 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.

4. A loss of coverage in the bankruptcy context is a substantial elimination of coverage within one year before or after the bankruptcy proceeding began.

Q: How long does the Mini-COBRA continuation of coverage last?

The continuation of coverage lasts up to 18 months for termination of employment (qualifying event).

Please note: A qualified beneficiary who, by law, 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 was, by law, 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 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 nondisabled family members who are entitled to continuation of coverage, those family members are also entitled to the 29-month disability extension.

Mini-COBRA lasts for 36 months for these qualifying events:

- Death of the employee
- Divorce or legal separation
- Loss of eligibility for a dependent child
- Employee becomes eligible for Medicare

For the qualifying event in regards to retirement, 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, their 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.

Q: 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.

Q: 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 their election rights within 14 days of knowledge of a qualifying event. The qualified beneficiary must provide you with notice within 60 days of the qualifying events of divorce, legal separation, or loss of eligibility for a dependent child as noted on page 25.
- 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 the instructions, related notices, and election form on pages 70-74 of the appendix for more details. You may wish to refer to these samples in drafting your forms.

Q: How much do I charge a qualified beneficiary for continuing coverage?

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.

Q: When are the premiums due?

The qualified beneficiary must remit payment within 45 days of the election date to allow reinstatement of coverage. The first payment is for the period from the date the person's group coverage ended through the current month.

Subsequent premium payments are due each month on your regular billing cycle. However, Mini-COBRA members can remit payment within 30 days of the first day of their monthly coverage period to you. You aren't obligated to send us premium payments for a Mini-COBRA member until you receive payment from that member.

Q: When can you cancel the Mini-COBRA continuation of coverage?

An employer may cancel a qualified beneficiary'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 doesn't contain any exclusions or limitations (i.e., waiting period or pre-existing condition clauses), after electing continuation of coverage

Q: What happens when the qualified beneficiaries reach the end of their continuation period?

The qualified beneficiaries are given the option to enroll in a nongroup plan.

Q: How do I administer enrollment of the member?

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

- It removes you from the financial burden of paying for the member's premium while they are deciding whether to accept or decline the continuation of coverage.
- It offers the member one of our nongroup plans. The member, if eligible for coverage under nongroup rules, would then have two options to choose from (continuation of coverage or nongroup). See the discussion on the following page regarding the separate offer of our nongroup plans.

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), they'll have coverage reinstated, retroactive to the qualifying event.

Q: 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'll bill you for the member on a monthly basis. It will appear as if the member were still an employee of your company. It's your responsibility to monitor and receive their monthly payment. If 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, 2021. 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, 2021.

The employer notifies Mr. Smith on June 1, 2021 (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, 2021, Mr. Smith advises XYZ Corp. that he wishes to elect continuation of coverage (the 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, 2021), payment in this example would be for five months of premiums (June through October).

Once payment has been made, XYZ Corp. advises Blue Cross Blue Shield of Massachusetts of Mr. Smith's continuation of coverage election and submits an Enrollment and Change form to reinstate Mr. Smith back to June 1, 2016.

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.

May 24, 2021
Member leaves company

June 1, 2021
Qualifying event (last day of coverage)

July 31, 2021
Election date (60 days available)

September 14, 2021
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 service consultant at their direct phone number or via our general phone number at **1-617-246-5000**.

Blue Cross Blue Shield of Massachusetts Nongroup Plans

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 possible options include:

- Continuation of group coverage under COBRA or Mini-COBRA
- Enrollment in one of our nongroup plans

The letter mentions the possible option of continuing group coverage under COBRA or Mini-COBRA, but it refers the member to you for further details. So please understand that this letter to members doesn't replace or satisfy your obligations to notify members of their rights to continue group coverage with you under COBRA or Mini-COBRA. You still have a responsibility under these laws to provide such notice to your employees. However, the letter also indicates that the member may be able to continue coverage by enrolling in one of our nongroup plans.

If a member is eligible for nongroup coverage, Blue Cross Blue Shield of Massachusetts can offer the a choice of plans. To find out more 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 doesn't allow us to enroll any individual who resides outside of Massachusetts.

These members can either:

1. Continue group coverage under COBRA or Mini-COBRA, or
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 Department of Insurance in their state of residence for other coverage options.

See pages 70-74 of the appendix for a sample of the Mini-COBRA Continuation Coverage Election Notice.

SECTION 6

WHEN A MEMBER BECOMES ELIGIBLE FOR MEDICARE

Medicare Members

Please note: Employers should seek the advice of their own legal counsel for Medicare Secondary Payer (MSP) 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: If an employee's 65th birthday falls between August 2 and August 31, the Medicare effective date is August 1. If an employee's 65th birthday is August 1, the 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, they are subject to a law (TEFRA) that 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: If the first Social Security disability benefit check covers the month of September, the Medicare effective date is September 1, two years later.

3. End-Stage Renal Disease (ESRD) Entitlement

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
- The first day of the month in which a person begins a self-administered dialysis program at home
- The first day of the fourth month following three months of provider-administered dialysis at a health facility

Examples: If 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.

If the person begins a program of home dialysis on November 21, then the Medicare effective date is November 1.

If 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 MSP laws:

Medicare Is Secondary Payer When:			
MSP Law	Employer Has	Medicare Member Is	
Working Aged	20 or more employees[1]	Age 65+ active employee	Age 65+ spouse of an active employee
Disability	100 or more employees[2]	Under age 65 active employee	Under age 65 dependent of an active employee
ESRD	All employers	Under age 65 active employee or retiree	Under age 65 dependent of an active employee or retiree

For the first 30 months of the ESRD Medicare entitlement

1. Twenty or more full-time 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.

2. One hundred 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

Medicare members subject to an MSP law cannot be enrolled in the employer's group plan that is a Medicare supplement, Medicare wrap, or Medicare replacement plan. The employer may not:

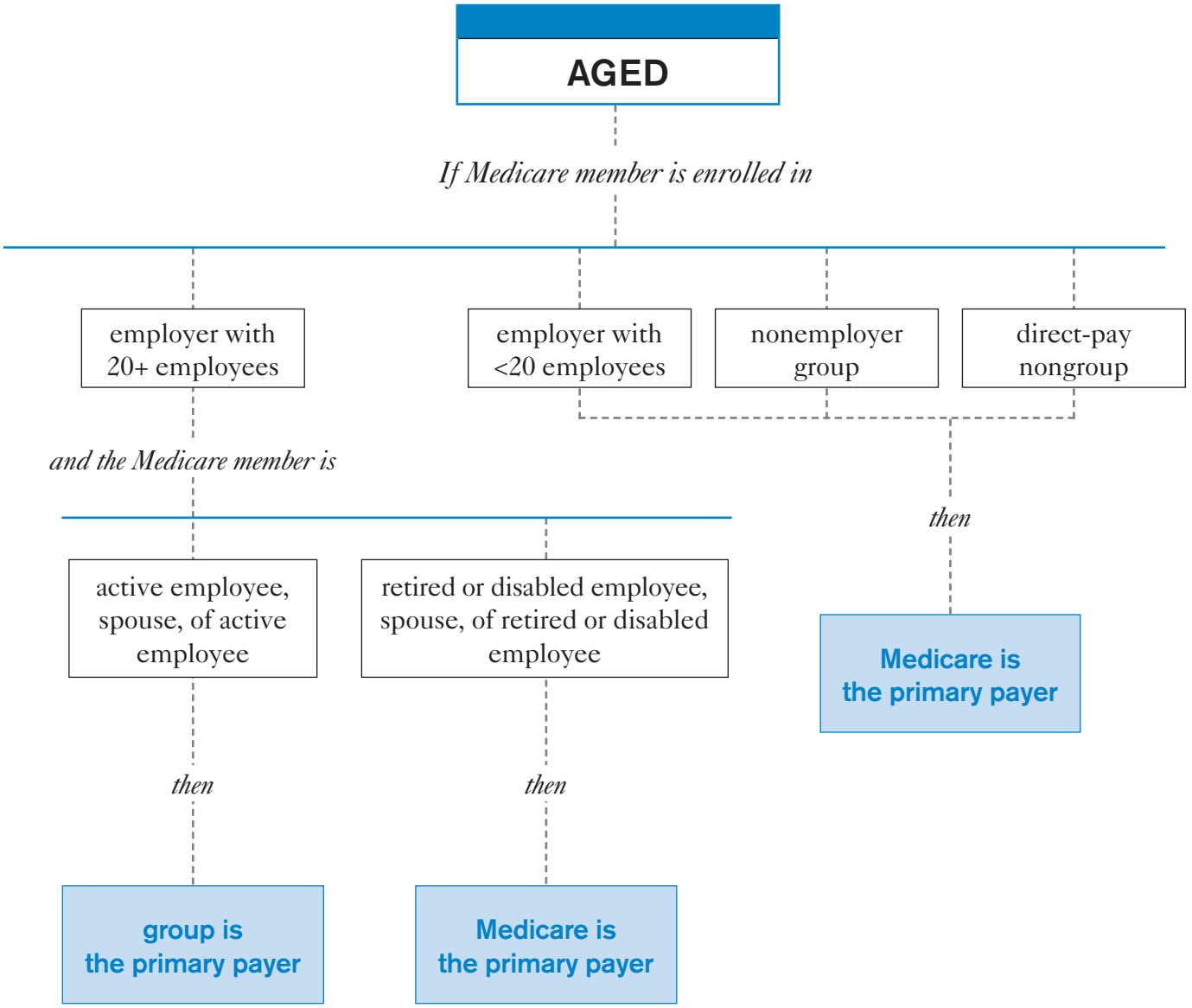
- Induce the member to elect Medicare as the primary payer (election is allowed under the Working Aged law)
- Prevent the member from enrolling in the employer's primary plan
- Sponsor or contribute toward any plan for the member that pays secondary to Medicare

Please note: Please contact your account service consultant for instructions.

See page 75 of the appendix for a sample of the Medicare Secondary Payer letter and survey.

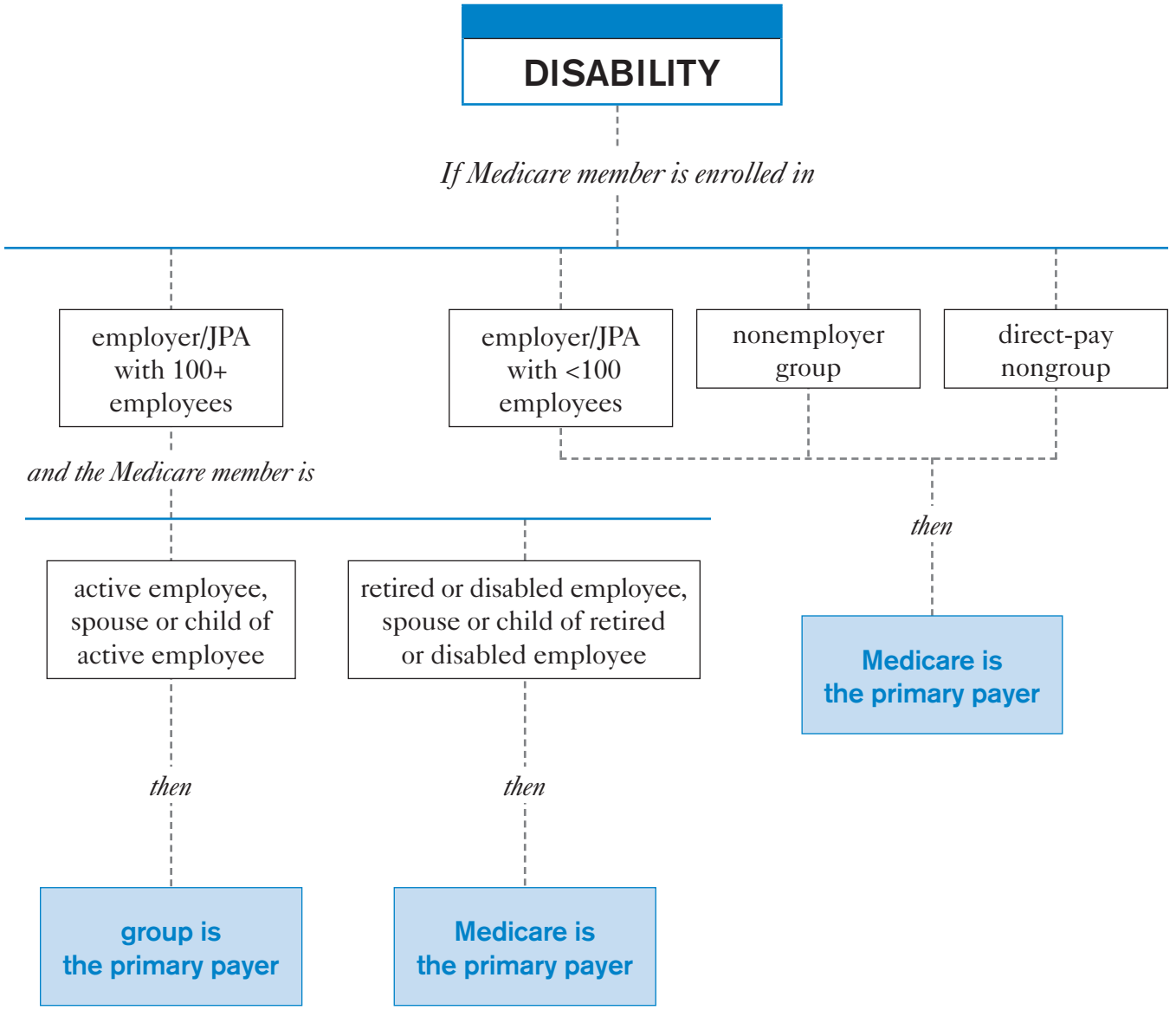
When a Member Becomes Eligible for Medicare

Primacy decision under Medicare Secondary Payer laws when the Medicare member is 65+ and entitled to Medicare based solely on age:



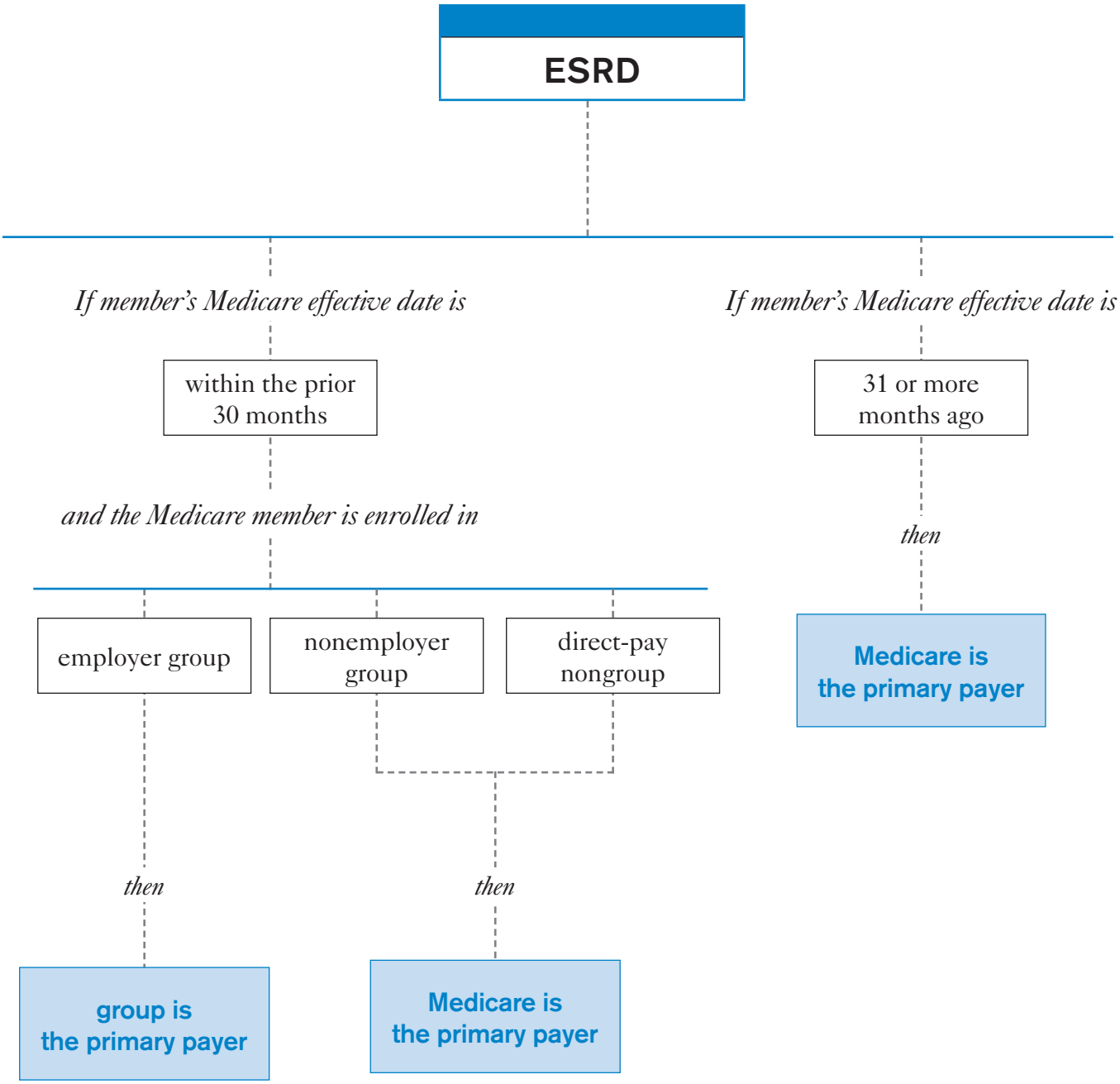
When a Member Becomes Eligible for Medicare

Primacy decision under Medicare Secondary Payer laws when the Medicare member is entitled to Medicare based solely on disability:



When a Member Becomes Eligible for Medicare

Primacy decision under Medicare Secondary Payer laws when the Medicare member is <65 and entitled to Medicare based solely on end-stage renal disease (ESRD):



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 the primary payer during the first 30 months of the member's ESRD Medicare coverage.

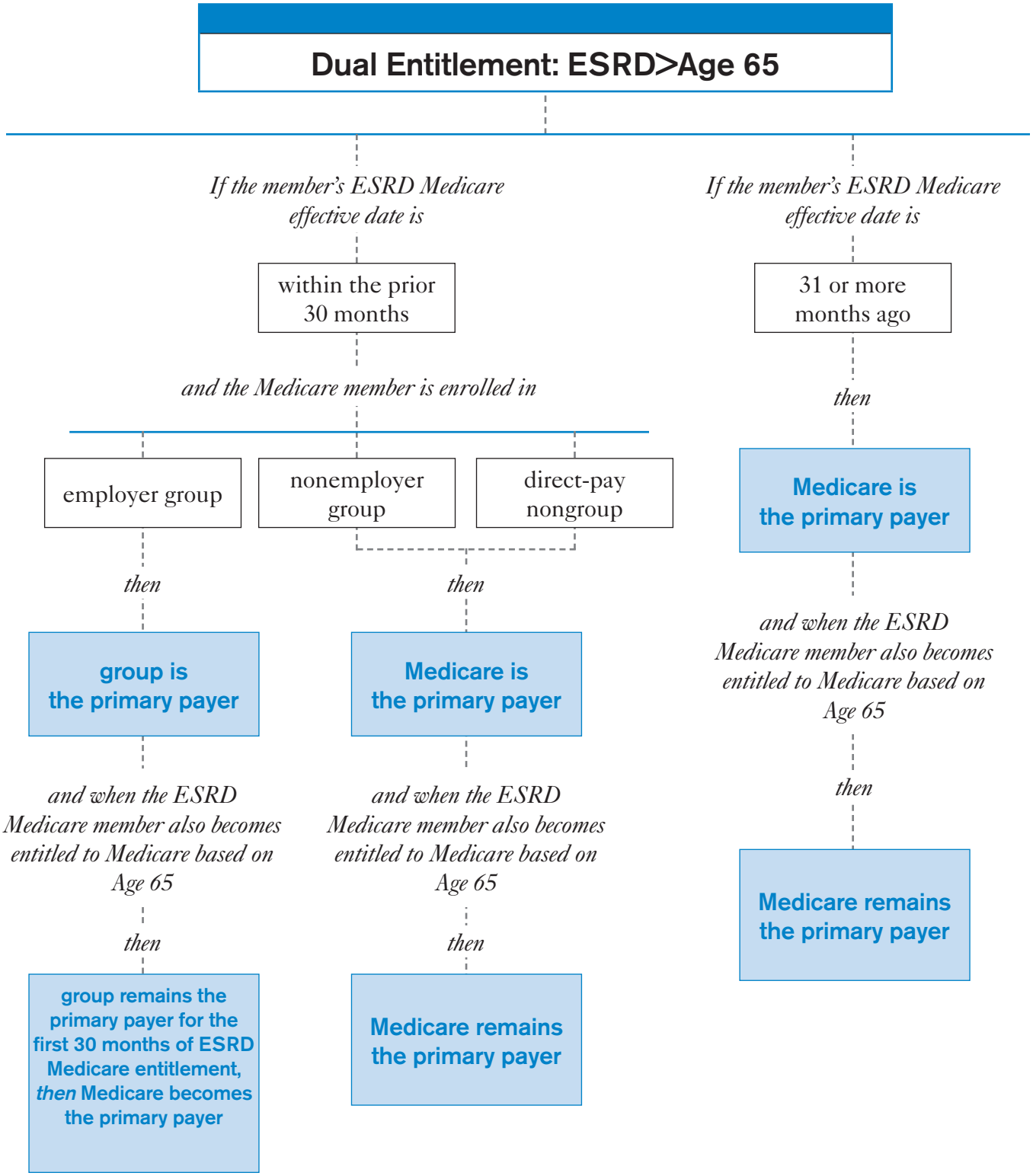
For Members Enrolled in an Employer's Group Health Plan

- 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 the primary payer until the end of the 30-month period. Thereafter, Medicare becomes and remains the primary payer for as long as the member remains dual Medicare entitled.
  - **Example:** ESRD Medicare is effective June 1, 2021. Age 65/Disability Medicare is effective February 1, 2022.
  - **Result:** Employer's plan is the primary payer until November 30, 2021. Medicare is the primary payer December 1, 2021, and remains so thereafter.
- 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 the primary payer for as long as the member remains dual Medicare entitled.
  - **Example:** ESRD Medicare is effective September 1, 2018. Age 65/Disability Medicare is effective May 1, 2021.
  - **Result:** Medicare is the primary payer from March 1, 2021. Medicare remains the primary payer thereafter.
- When the Age 65/Disability entitlement precedes the ESRD entitlement, and the employer's plan is the primary payer under the Working Aged (TEFRA) or Disability law, then the employer's plan remains the primary payer during the first 30 months of the ESRD coverage period. Thereafter, Medicare becomes and remains the primary payer for as long as the member remains dual Medicare entitled.
  - **Example:** Age 65/Disability Medicare is effective June 1, 2020. ESRD Medicare is effective February 1, 2021. 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 the primary payer until July 31, 2023. Medicare becomes the primary payer August 1, 2023, and remains so thereafter.
- When the Age 65/Disability entitlement precedes the ESRD entitlement but Medicare is the primary payer under the Working Aged or Disability law, then Medicare remains the primary payer for as long as the member remains dual Medicare entitled.
  - **Example:** Age 65/Disability Medicare is effective June 1, 2020. ESRD Medicare is effective February 1, 2021. Employer has <20/<100 employees or Medicare member is an inactive or retired employee or dependent of an inactive or retired employee.
  - **Result:** Medicare became the primary payer June 1, 2020. Medicare remains the primary payer thereafter.

See page 75 of the appendix for an example of the Medicare Secondary Payer letter and survey.

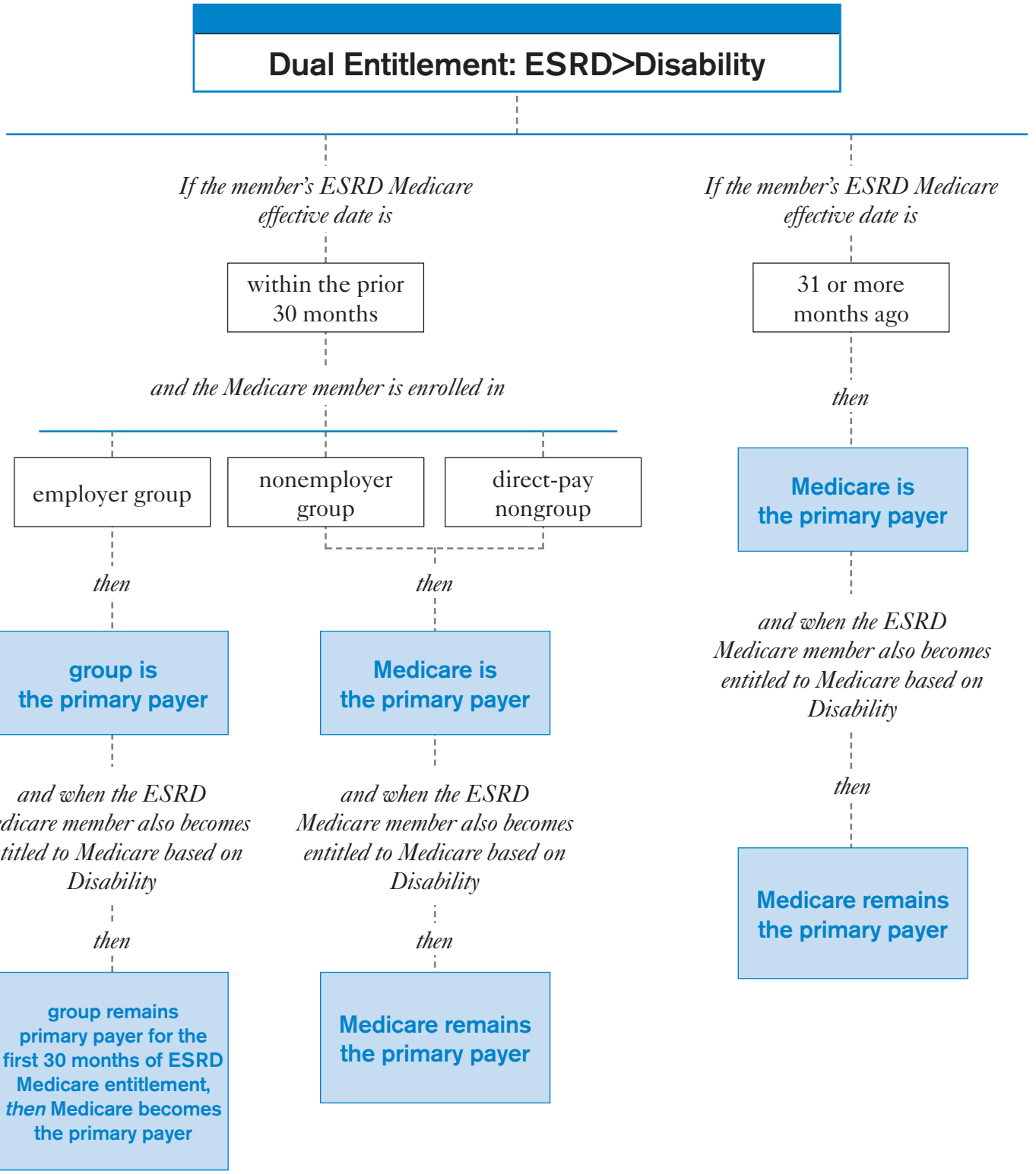
When a Member Becomes Eligible for Medicare

Primacy decision under Medicare Secondary Payer laws when the Medicare member is under 65 and entitled to Medicare based initially on end-stage renal disease and then reaches age 65:



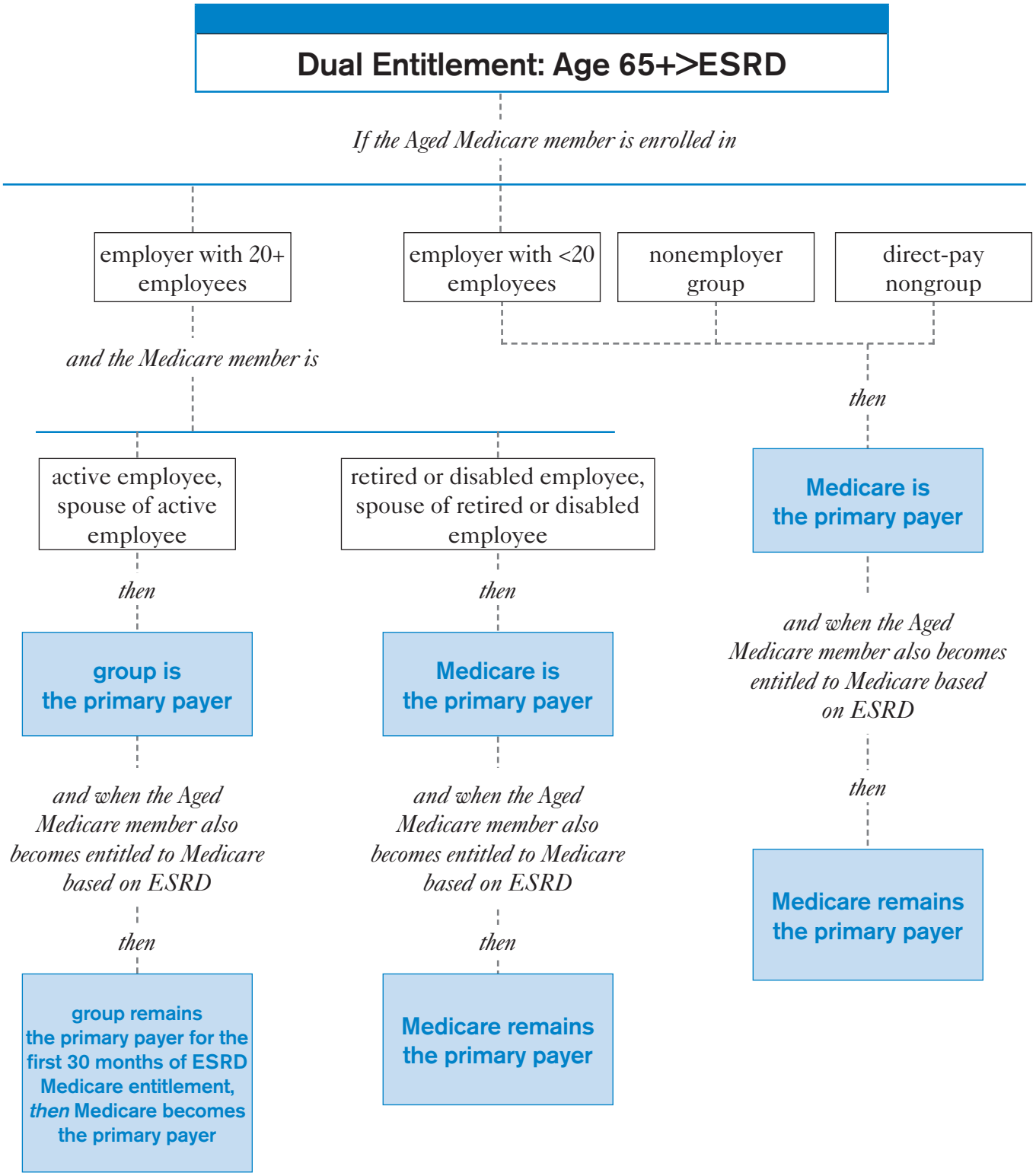
When a Member Becomes Eligible for Medicare

Primacy decision under Medicare Secondary Payer laws when the Medicare member is under 65 and entitled to Medicare, based initially on end-stage renal disease and then on disability.



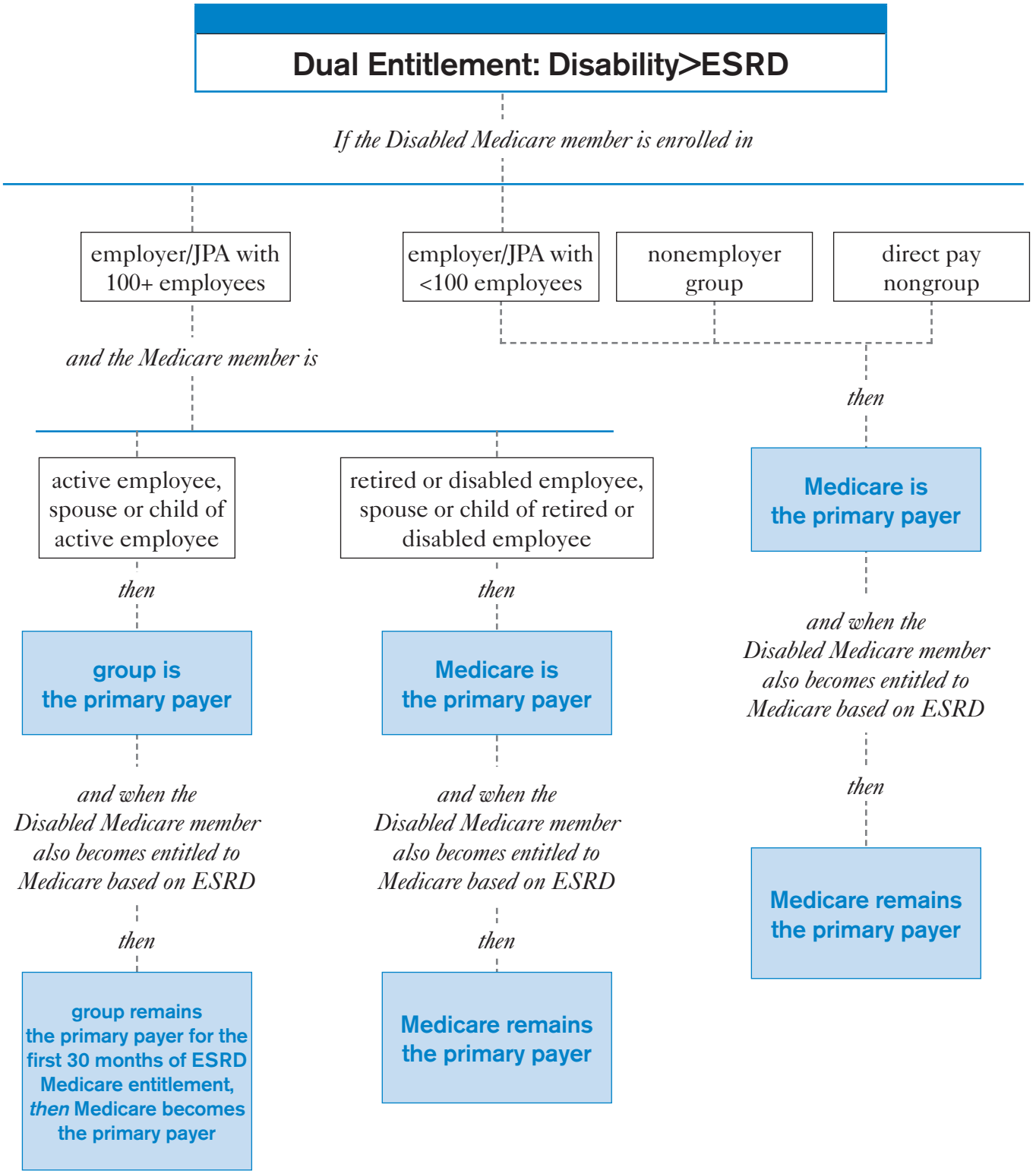
When a Member Becomes Eligible for Medicare

Primacy decision under Medicare Secondary Payer laws when the Medicare member is 65+ and entitled to Medicare based initially on age and then on ESRD:



When a Member Becomes Eligible for Medicare

Primacy decision under Medicare Secondary Payer laws when the Medicare member is 65+ and entitled to Medicare based initially on a disability and then on ESRD:



SECTION 7

OTHER PARTY LIABILITY

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

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

Primary and Secondary Coverage

In general, when a member has dual or multiple coverage, we follow the coordination of benefits 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
- 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.

Here are provisions for when and which health plans are primary or secondary:

1. The insurance plan or other coverage that doesn't 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 their 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 don't determine the order of liability, the health care plan that has covered the patient for the longer period is primary.
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 remaining balance if our health care plan requirements have been met.

No Fault

Most Massachusetts residents have Personal Injury Protection (PIP) insurance coverage—coverage for vehicles, medical bills, lost wages, and funeral expenses. PIP generally covers the first $2,000 in medical costs. After that—depending on whether the plan is insured or self-funded and whether there is other coverage included in auto insurance—your plan may become responsible for medical costs alone. If there is coverage beyond the initial $2,000 in PIP benefits, we defer to the auto insurance coverage.

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 auto 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 pursuing subrogation proceeding under the Employee Retirement Income Security Act of 1974 (ERISA), or by establishing a statutory lien under General Laws Chapter 111, Section 70A. Members are obligated to provide all requested information that is necessary to establish a claim or statutory lien.

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 other law.

Medicare

See "When a Member Becomes Eligible for Medicare" on page 29.

SECTION 8

ACCOUNT BILLING AND PREMIUM INFORMATION

Overview

Under fully insured billing, you pay us a monthly premium based on a rate determined by our underwriting department. We issue monthly invoices, which reflect all membership transactions and payments since your last invoice.

Invoices We'll Send You

Your invoice is based on the determined rate (individual, family, etc.) multiplied by the number of subscribers within each group. The amount may fluctuate based on the number of enrollees and other activity that occurs within the billing period. Invoices are generated approximately 15 days before the due date. Blue Cross Blue Shield of Massachusetts is proud to offer paperless electronic bill presentment and payment. With eBilling, you'll receive an email alert as soon as your invoice is generated. eBilling allows you to view and pay your invoice(s) online.

More on eBilling

Our eBilling site can help you reduce the paperwork associated with your insurance invoices, and give you more control over payments and reporting. That's because eBilling combines all of your Blue Cross Blue Shield of Massachusetts premium invoices in one place and lets you pay online with one click.

Getting started is easy. New accounts with 1-99 subscribers will be automatically set up on eBilling, and an email will be sent to the account's billing contact with instructions on how to sign in. For large accounts with more than 100 subscribers, please send an email to **payment.inquiry@bcbsma.com** that includes the following information:

- Your name
- Phone number
- Email address
- Account name
- Group numbers
- Billing address

Once you sign in to the secure site, you can:

- Make online payments at no charge
- Set up recurring debits from your bank
- Sort and export invoices to Excel or PDF
- Access reporting tools, as well as an 18-month archive of your invoices and payments
- View and manage multiple invoices
- Manage or limit user permissions and access, and offer simultaneous multi-user access

If you have any further questions about eBilling, please contact your Blue Cross Blue Shield of Massachusetts Customer Financial Management Analyst at **1-888-751-5607**, Monday through Friday, from 8:30 a.m. to 4:00 p.m. ET.

See pages 77-78 of the appendix for an example of an eBilling invoice for a premium account.

Payment Guidelines

For our fully-insured accounts, we offer the option of six different due dates to pay the premium: the 1st, 5th, 10th, 15th, 20th, and 25th of each month.

To ensure claim payment, we require receipt of your payment(s) on or before the due date. You must pay the invoice amount as billed. The deduction of anticipated enrollment credits (i.e., "shortpaying") on an invoice is prohibited without the consent of our Customer Financial Management Department. If you don't pay the invoice amount as billed or by the due date, then we reserve the right to assess a late fee of up to 1.5% of the amount past due. In addition, you may be at risk of cancellation for non-payment of premium. Therefore, we encourage you to speak with your dedicated Customer Financial Management Analyst if you have questions about the invoice amount.

The Attorney General has issued regulations for the non-payment cancellation of group health insurance premiums. The regulations require us to notify subscribers in writing to tell them that their health insurance has been canceled because their employer didn't pay the required premiums for the coverage. The regulations also require us to provide the notification within 60 days of the effective date of the cancellation and to include Temporary Continuation of Group Coverage Options to qualifying subscribers and their dependents.

Payment Options

For your convenience, we offer the following payment options:

- **Payment via eBilling.** This is our preferred invoice and payment method. eBilling allows you the ability to pay by either of the following two options: (1) pay your bill online each month, or (2) automatically schedule your payments to be made each month through our auto-draft option. Please note: you'll need to allow up to three days for your payment to be processed.
- **Payment via online banking.** By setting up payments that your bank automatically makes each month or one-time payments that you approve each time. To set up payment, you need:
  - group number (separate payments must be set up for each group number)
  - Payment address:
    Blue Cross Blue Shield of Massachusetts
    BOX 371318
    Pittsburgh, PA 15250-7318

Important Information Regarding your Payment

Your payment should cover the total amount due indicated on your invoice. If you sent last month's premium too late for it to appear as a credit on this month's statement, you may deduct the amount of your previous payment once confirming its receipt with a Customer Financial Management Analyst. Otherwise, if you don't pay as billed you may be at risk of being assessed a late fee of up to 1.5% per month for the amount past due and canceled for non-payment of premium. If you're unsure about the amount to pay, then please call us at **1-888-751-5607**, Monday through Friday, from 8:30 a.m. to 4:30 p.m. ET.

If You Need Assistance

If you have questions about your invoice, please call **1-888-751-5607**. A Customer Receivables Management Analyst can help you Monday through Friday, 8:30 a.m. to 4:00 p.m. ET, or you can send us an email at **payment.inquiry@bcbsma.com**.

SECTION 9

SUBMITTING A CLAIM

Under most plans, members don't need to submit claim forms. Participating providers within Massachusetts and providers that have an agreement with the local Blue Cross 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.

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 consultant, or download electronic claim forms from the Fast Forms section of Learn & Save at **bluecrossma.org**. 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.

10 SECTION 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'll 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 don't 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. They'll work with you to meet your group's specific needs.

SECTION 11

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 Rule

HIPAA restricts pre-existing condition limitations with certain restrictions. These restrictions are unlikely to affect Blue Cross Blue Shield of Massachusetts plans since we don't generally place pre-existing condition limitations on any of our products.

Creditable Coverage

Creditable coverage is defined as a member's most recent previous coverage, including COBRA coverage.

Creditable Coverage Certificates

The group health plan (employer or trust) or insurer is 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. 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 consultant should you wish to send certificates of coverage to your terminated members.

A member is also entitled to receive a certificate when their claim is denied because the lifetime maximum is exhausted.

Discrimination Prevention

HIPAA prohibits limiting enrollment or continued enrollment based upon the following conditions:

- Health status
- A specific medical condition
- Medical history
- Claims history
- Genetic information
- Evidence of insurability
- Disability

Enrollment Requirements for Small-Group Market

HIPAA requires the availability of small group and individual market health insurance products.

How to Get More HIPAA Information

The U.S. Department of Labor provides additional information about HIPAA:

Call the Employee Benefits Security Administration hotline at **1-866-444-EBSA (3272)**.

Access more information online at **dol.gov**.

12 SECTION GLOSSARY

BluesEnroll

A benefits and enrollment management tool. Offered in partnership with Benefitfocus, a leading provider of cloud-based benefit management services, BluesEnroll seamlessly coordinates the efforts of benefit administrators, employees, and brokers on a single platform.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986)

Federal legislation that provides for the continuation of coverage for members who 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 percentage of their 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 isn't paid more than once. Other insurance plans and coverage include personal injury insurance, auto insurance, homeowner's insurance, and other insurance policies or health benefit plans that cover hospital or medical expenses.

Diagnostic Related Group (DRG)

An inpatient reimbursement system based on certain claims 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 per DRG case.

eBilling

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:

- Severe pain—severe enough to jeopardize your or another's health
- Serious impairment of bodily functions
- Serious dysfunction of any part or organ of your body
- Any condition that could result in severe pain that cannot be managed without emergency care

Examples include suspected heart attacks, stroke, poisoning, loss of consciousness, seizures, and suicide attempts.

Electronic Enrollment EDI File

An application for our accounts with 150 or more subscribers that systematically takes data in from a payroll or HR system, compares it to our enrollment eligibility database, and makes the appropriate changes, if needed.

Enrollment Area (applies to managed care plans)

The geographic area where each member must be a permanent resident to be covered by the plan.

Gatekeeper (applies to managed care plans)

Term applied to certain managed health care plans in which the primary care provider oversees and approves all medical care needs of patients.

Health Maintenance Organization (HMO)

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 doctor-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 caretaker 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

A situation where a person is confined in a hospital as a registered bed patient and necessary services are provided on an inpatient basis, in contrast to an outpatient or 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 isn't considered a registered inpatient.)

Lifetime Maximum

The maximum benefit amount the plan will pay for a member while they are 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—as well as disabled and other qualifying events—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.

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.

Point of Service (POS)

A gatekeeper health care program that provides a higher level of coverage when the member uses the health care services of a network provider. The member receives a lower level of coverage for health care services provided by a non-network provider.

Preferred Provider Organization (PPO)

A non-gatekeeper health care program that provides a higher level of coverage when the member uses the health care services of 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 provided in an attempt to detect health problems rather than treat them after they occur.

Primary Care Provider (PCP) (applies to managed care plans)

The doctor responsible for a member's everyday health care needs, including diagnosis, treatment, and, when necessary, referrals. Members can select their own PCPs who are within their health plan network.

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.

Service Area (applies to managed care plans)

The area defined by the managed care plan as the geographic area in which services are rendered.

Skilled Nursing Facility (SNF)

A facility that provides different levels of care, ranging from skilled nursing care and skilled rehabilitative care to custodial care. (Custodial care isn't covered under Blue Cross Blue Shield of Massachusetts plans.)

Specialty Care Physician (SCP) (applies to managed care plans)

Any managed care physician not classified as a primary care provider.

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 an auto accident.

Subscriber

The person who signs the enrollment application for self and dependents, if applicable at the time of initial enrollment for coverage. Or, the primary member of the plan.

Urgent Care (applies to managed care plans)

Medical, surgical, or psychiatric (mental health or substance abuse) care other than emergency care that the member needs in order to prevent serious deterioration of their health if or a condition that isn't life-threatening. Examples include facilities that treat sprains, minor burns, or even broken bones.
These facilities are also open seven days a week, frequently have evening hours, and are about the same cost as a visit to your doctor's office.

13 SECTION APPENDIX

Contents

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group # Transfering To:

Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group # Transferring To

Type of Transaction	Remarks: (i.e., qualifying event for a new add, change to family or other instruction)		
❒ ADD ❒ CANCEL ❒ CHANGE Three digit ❒ TRANSFER termination code ☐☐☐	❒ Open Enrollment ❒ New Hire ❒ COBRA	Change to Family ❒ Add Spouse ❒ Add Dependent	❒ Loss of Coverage (HIPAA Continuation of Coverage Letter required) ❒ Other: _____

2. Yourself (Member 1)

What products?					Membership Type (Medical)	Membership Type (Dental)
❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England	❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue	❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group)	❒ Network Blue ❒ PPO ❒ Saver Blue		❒ Individual ❒ Family	❒ Individual ❒ Family

First Name	M.I.	Last Name	Sex	Date of Birth

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Home Phone ( )	Cell Phone ( )	Email

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ❒ / N ❒	❒ 65+ ❒ Disabled ❒ ESRD / If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered) Plan Type: ❒ Medical ❒ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ❒ / N ❒	❒ 65+ ❒ Disabled ❒ ESRD / If Retired, Date

4. Your Eligible Dependents (Member 3, 4 and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

☐ **HSA: Health Savings Account**	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

How to Complete the Enrollment and Change Form

This is an example and explanation of how to complete the Enrollment and Change form:

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:

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

0 1 2 3 4 5 6 7 8 9

The *employer* should fill in Section 1:

Fill in your company's name and current medical group numbers.

If the employee is transferring to another health plan administered by Blue Cross Blue Shield of Massachusetts, enter the new group number(s).

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name		Current Medical Group #:	Medical Group #, Transferring To
Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group #, Transferring To
Type of Transaction ❒ ADD ❒ CANCEL ❒ CHANGE Three digit ❒ TRANSFER termination code	Remarks: (i.e., qualifying event for a new add, change to family or other instruction)			
	❒ Open Enrollment ❒ New Hire ❒ COBRA	Change to Family ❒ Add Spouse ❒ Add Dependent	❒ Loss of Coverage (HIPAA Continuation of Coverage Letter Required) ❒ Other: _____	

Indicate whether you're adding, changing, or terminating the employee's coverage.
If terminating, enter the appropriate code:

061 Left Employ
070 Deceased
042 Over 65 (Transferring to HMO Senior Plan)
042 Over 65 (Transferring to group Medex®)
042 Over 65 (Transferring to nongroup Medex)
071 Moved from Service Area
061 COBRA End
041 Voluntary (Other than above)–Employee signature required

(See Changing a Member's Status on page 19 for further information about changing or terminating an employee's coverage.)

Enter the employee's current Blue Cross Blue Shield of Massachusetts ID number, if already enrolled.

Enter the requested effective date of coverage and the employee's date of hire.

If your new hires are subject to a probationary period, please indicate the time frame in the **Remarks** section. Also, if the member's initial eligibility date is different from the date of hire, explain why here (e.g., marriage, birth, civil union, domestic partner, employee or retiree over age 65, etc.).

The *employee* should complete the following:

What Products Are You Selecting?
The employee indicates the coverage desired.

Kind of Membership
The employee should indicate whether he or she is joining as an individual or as a family.

2. Yourself (Member 1)						
What products?	❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England	❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue	❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group)	❒ Network Blue ❒ PPO ❒ Saver Blue	Membership Type (Medical) ❒ Individual ❒ Family	Membership Type (Dental) ❒ Individual ❒ Family

Tell Us About Yourself (Member 1)
The employee fills in their name, address, sex, date of birth, social security number, and phone number, as well as the provider number for the primary care provider[1] (for managed care plans, such as **HMO and POS**). The PCP's provider number is listed in the provider directory of the chosen health plan.

Your First Name	M.I.	Last Name		Sex	Date of Birth
Street Address/ P.O. Box #	Apt. #	City/ Town		State	Zip Code
Home Phone ( )	Cell Phone ( )	Email			
Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	City / State		
PCP ID # (see instructions)	Name of PCP	City / State		Is this your current PCP? Y ❒ / N ❒	
Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ❒ / N ❒	❒ 65+ ❒ Disabled ❒ ESRD / If Retired, 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, they should fill in the insurer's name, city, and state.

3. Member 2	Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered)			Plan Type: ❒ Medical ❒ Dental	
First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	City / State	
PCP ID # (see instructions)	Name of PCP	City / State		Is this your current PCP? Y ❒ / N ❒	
Are you covered by Medicare?[2] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare # / Actively Working? Y ❒ / N ❒	❒ 65+ ❒ Disabled ❒ ESRD / If Retired, Date

If the employee or spouse is covered by Medicare, they should check "Y" and fill in the Medicare number.

1. 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 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.

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental	
Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental	
Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ❒ / N ❒	Full-time student and aged 19 or older ❒	Disabled and aged 26 or older ❒	Plan Type: ❒ Medical ❒ Dental	

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

☐ **HSA: Health Savings Account**	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

Be sure you and the employee sign and date the form.

Each family member can choose a different PCP. If the employed, spouse, or dependents are enrolled in a managed care plan, and no PCP number is given, benefits cannot be guaranteed.

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

The following Enrollment and Change form shows **how to add a subscriber or employee to your plan.**

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name: ABC COMPANY			Current Medical Group #: 0000001		Medical Group #, Transferring To
Current BCBS ID #, If any	Requested Effective Date: 01 (MM) 01 (DD) 2007 (YYYY)		Date of Hire: 10 (MM) 10 (DD) 2007 (YYYY)	Current Dental Group #:	Dental Group #, Transferring To

Type of Transaction: [X] ADD [ ] CANCEL [ ] CHANGE [ ] TRANSFER — Three digit termination code: [ ][ ][ ]

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

[ ] Open Enrollment [X] New Hire [ ] COBRA

Change to Family: [ ] Add Spouse [ ] Add Dependent

[ ] Loss of Coverage (HIPAA Continuation of Coverage Letter Required)

[ ] Other: _____

2. Yourself (Member 1)

What products? [ ] Access Blue [ ] Blue Choice [ ] Blue Choice New England [ ] Blue Medicare Rx (Part D) [ ] Dental Blue [X] HMO Blue [ ] HMO Blue New England [ ] Managed Blue for Seniors [ ] Medex (Group) [ ] Network Blue [ ] PPO [ ] Saver Blue

Membership Type (Medical): [ ] Individual [ ] Family

Membership Type (Dental): [ ] Individual [ ] Family

Your First Name: SAMUEL	M.I.: S	Last Name: SAMPLE		Sex: M	Date of Birth: 04/22/1970
Street Address/ P.O. Box #: 401 PARK DRIVE	Apt. #	City/ Town: BOSTON		State: MA	Zip Code: 02215
Home Phone (617) 555-1111	Cell Phone ( )	Email			
Social Security # (REQUIRED)[1]: 000 000 000	Other Insurance?[2] Y [ ] / N [X]	Other Insurance Company Name		City / State	
PCP ID # (see instructions): 700J00000	Name of PCP: DR. B CROSS	City / State: BOSTON, MA		Is this your current PCP? Y [X] / N [ ]	

Are you covered by Medicare?[2] Y [ ] / N [X]

Part A Effective Date (MM DD YYYY) | Part B Effective Date (MM DD YYYY) | Part D Effective Date (MM DD YYYY)

Medicare #

Actively Working? Y [ ] / N [ ]

[ ] 65+ [ ] Disabled [ ] ESRD

If Retired, Date

3. Member 2

Please Check One: [ ] Spouse [ ] Domestic Partner [ ] Divorced Spouse (court ordered)

Plan Type: [ ] Medical [ ] Dental

First Name: SUSAN	M.I.: B	Last Name: SAMPLE		Sex: F	Date of Birth: 07/21/1972
Social Security # (REQUIRED)[1]: 000 000 001	Phone (617) 555-1111	Other Insurance?[2] Y [ ] / N [X]	Other Insurance Company Name	City / State	
PCP ID # (see instructions): 700J00000	Name of PCP: DR. B CROSS	City / State: BOSTON, MA		Is this your current PCP? Y [X] / N [ ]	

Are you covered by Medicare?[2] Y [ ] / N [ ]

Part A Effective Date (MM DD YYYY) | Part B Effective Date (MM DD YYYY) | Part D Effective Date (MM DD YYYY)

Medicare #

Actively Working? Y [ ] / N [ ]

[ ] 65+ [ ] Disabled [ ] ESRD

If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y [ ] / N [ ]	Full-time student and aged 19 or older [ ]	Disabled and aged 26 or older [ ]	Plan Type: [ ] Medical [ ] Dental	
Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y [ ] / N [ ]	Full-time student and aged 19 or older [ ]	Disabled and aged 26 or older [ ]	Plan Type: [ ] Medical [ ] Dental	
Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y [ ] / N [ ]	Full-time student and aged 19 or older [ ]	Disabled and aged 26 or older [ ]	Plan Type: [ ] Medical [ ] Dental	

Please check if you are using separate forms for additional dependent children [ ]

Total # of dependents: _____

5. Personal Savings Account

[ ] HSA: Health Savings Account	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
[ ] FSA: Health Flexible Spending Account	Start Date	End Date	Health: $
[ ] FSA: Dependent Care Reimbursement Account	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature: Samuel Sample Date: 1/3/07 Employer's Signature: Frank Fake Date: 1/4/07

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

Blue Cross Blue Shield of Massachusetts is an Independent Licence of the Blue Cross and Blue Shield Association.

Please note: We need birth dates of the subscriber, spouse, and eligible dependents to issue ID cards. Both the employee and the employer must sign and date the application. **We cannot process incomplete or unsigned applications.**

The following Enrollment and Change form 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 "Enrolling Employees in a Health Plan", on page 3, for additional instructions on completing the Enrollment and Change form.

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transferring To
ABC COMPANY	0000000	

Current BCBS ID #, If any	Requested Effective Date	Date of Hire	Current Dental Group #:	Dental Group #, Transferring To
999999999	05 (MM) 21 (DD) 2007 (YYYY)	01 (MM) 01 (DD) 2007 (YYYY)	0000001	

Type of Transaction
☒ ADD ☐ CANCEL
☐ CHANGE Three digit termination code ☐☐☐
☐ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction) ADD SPOUSE AS OF DATE OF MARRIAGE 5/21/07

☐ Open Enrollment ☐ New Hire ☐ COBRA
Change to Family: ☒ Add Spouse ☐ Add Dependent
☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
☐ Other: _____

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice ☐ Blue Choice New England ☐ Blue Medicare Rx (Part D) ☐ Dental Blue ☒ HMO Blue ☐ HMO Blue New England ☐ Managed Blue for Seniors ☐ Medex (Group) ☐ Network Blue ☐ PPO ☐ Saver Blue

Membership Type (Medical): ☐ Individual ☒ Family
Membership Type (Dental): ☐ Individual ☒ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
SAMUEL	S	SAMPLE	M	04/22/1970

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code
401 PARK DRIVE		BOSTON	MA	02215

Home Phone	Cell Phone	Email
(617) 555-0000	( )	

Social Security # (REQUIRED)[1]	Other Insurance?[2]	Other Insurance Company Name	City / State
000 000 000	Y ☐ / N ☒		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
700J00000	DR. B CROSS	BOSTON, MA	Y ☒ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #		
Y ☐ / N ☒	MM DD YYYY	MM DD YYYY	MM DD YYYY		☐ 65+ ☐ Disabled ☐ ESRD	
				Actively Working? Y ☐ / N ☐	If Retired, Date	

3. Member 2 Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered) Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth
SUSAN	B	SAMPLE	F	07/21/1972

Social Security # (REQUIRED)[1]	Phone	Other Insurance?[1]	Other Insurance Company Name	City / State
000 000 001	(617) 555-0000	Y ☐ / N ☒		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
700J00000	DR. B CROSS	BOSTON, MA	Y ☒ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #		
Y ☐ / N ☒	MM DD YYYY	MM DD YYYY	MM DD YYYY		☐ 65+ ☐ Disabled ☐ ESRD	
				Actively Working? Y ☐ / N ☐	If Retired, Date	

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Please check if you are using separate forms for additional dependent children ☐ Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	
☐ HSA: Health Savings Account			FSA Goal Amount (Please see instructions for limits.): $
☐ FSA: Health Flexible Spending Account			Health: $
☐ FSA: Dependent Care Reimbursement Account			Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature Samuel Sample Date 5/30/07 Employer's Signature Frank Fake Date 5/30/07

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

Blue Cross Blue Shield of Massachusetts is an Independent Licence of the Blue Cross and Blue Shield Association.

The following Enrollment and Change form shows **how to change an address**. You may also use this example for other member changes.

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transferring To
ABC COMPANY	0000000	

Current BCBS ID #, If any	Requested Effective Date	Date of Hire	Current Dental Group #	Dental Group #, Transferring To
999999999	04 (MM) 30 (DD) 2007 (YYYY)	(MM DD YYYY)		

Type of Transaction
- ☐ ADD
- ☐ CANCEL
- ☒ CHANGE
- ☐ TRANSFER

Three digit termination code: ☐☐☐

Remarks: (i.e., qualifying event for a new add, change to family or other instruction) PLEASE UPDATE NEW ADDRESS

- ☐ Open Enrollment
- ☐ New Hire
- ☐ COBRA

Change to Family
- ☐ Add Spouse
- ☐ Add Dependent

- ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
- ☐ Other: _____

2. Yourself (Member 1)

What products?
- ☐ Access Blue
- ☐ Blue Choice
- ☐ Blue Choice New England
- ☐ Blue Medicare Rx (Part D)
- ☐ Dental Blue
- ☒ HMO Blue
- ☐ HMO Blue New England
- ☐ Managed Blue for Seniors
- ☐ Medex (Group)
- ☐ Network Blue
- ☐ PPO
- ☐ Saver Blue

Membership Type (Medical): ☒ Individual ☐ Family

Membership Type (Dental): ☐ Individual ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
SAMUEL	S	SAMPLE	M	04/22/1970

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code
401 PARK DRIVE		BOSTON	MA	02215

Home Phone	Cell Phone	Email
(617) 555-0000	( )	

Social Security # (REQUIRED)[1]	Other Insurance?[2]	Other Insurance Company Name	City / State
000 000 000	Y ☐ / N ☒		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
700J00000	DR. B CROSS	BOSTON, MA	Y ☒ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #	
Y ☐ / N ☒	(MM DD YYYY)	(MM DD YYYY)	(MM DD YYYY)	Actively Working? Y ☐ / N ☐	☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date

3. Member 2

Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered) | Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ☐ / N ☐	Other Insurance Company Name	City / State

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
			Y ☐ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #	
Y ☐ / N ☐	(MM DD YYYY)	(MM DD YYYY)	(MM DD YYYY)	Actively Working? Y ☐ / N ☐	☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ | Full-time student and aged 19 or older ☐ | Disabled and aged 26 or older ☐ | Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ | Full-time student and aged 19 or older ☐ | Disabled and aged 26 or older ☐ | Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ | Full-time student and aged 19 or older ☐ | Disabled and aged 26 or older ☐ | Plan Type: ☐ Medical ☐ Dental

Please check if you are using separate forms for additional dependent children ☐ | Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ HSA: Health Savings Account			
☐ FSA: Health Flexible Spending Account	Start Date	End Date	Health: $
☐ FSA: Dependent Care Reimbursement Account	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature Samuel Sample Date 4/30/07 Employer's Signature Frank Fake Date 4/30/07

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

The following Enrollment and Change form shows **how to transfer a subscriber from one group to another** during Open Enrollment.

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transferring To
ABC COMPANY	0000001	0000002

Current BCBS ID #, If any	Requested Effective Date (MM DD YYYY)	Date of Hire (MM DD YYYY)	Current Dental Group #:	Dental Group #, Transferring To
999999999	01 01 2007	10 10 2006		

Type of Transaction
- ❒ ADD
- ❒ CHANGE
- ☒ TRANSFER
- ❒ CANCEL — Three digit termination code: 0 4 2

Remarks: (i.e., qualifying event for a new add, change to family or other instruction) TRANSFER FROM HMO TO PPO

- ❒ Open Enrollment
- ❒ New Hire
- ❒ COBRA

Change to Family
- ❒ Add Spouse
- ❒ Add Dependent

- ❒ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
- ❒ Other: _____

2. Yourself (Member 1)

What products?
- ❒ Access Blue
- ❒ Blue Choice
- ❒ Blue Choice New England
- ❒ Blue Medicare Rx (Part D)
- ❒ Dental Blue
- ❒ HMO Blue
- ❒ HMO Blue New England
- ❒ Managed Blue for Seniors
- ❒ Medex (Group)
- ❒ Network Blue
- ☒ PPO
- ❒ Saver Blue

Membership Type (Medical): ☒ Individual ❒ Family
Membership Type (Dental): ❒ Individual ❒ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
SAMUEL	S	SAMPLE	M	04/22/1970

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code
401 PARK DRIVE		BOSTON	MA	02215

Home Phone	Cell Phone	Email
(617) 555-0000	( )	

Social Security # (REQUIRED)[1]	Other Insurance?[2]	Other Insurance Company Name	City / State
000 000 000	Y ❒ / N ☒		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
			Y ❒ / N ❒

Are you covered by Medicare?[2]	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #		
Y ❒ / N ☒					❒ 65+ ❒ Disabled ❒ ESRD	
					Actively Working? Y ❒ / N ❒	If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered) — Plan Type: ❒ Medical ❒ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1]	Other Insurance Company Name	City / State
		Y ❒ / N ❒		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
			Y ❒ / N ❒

Are you covered by Medicare?[2]	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #		
Y ❒ / N ❒					❒ 65+ ❒ Disabled ❒ ESRD	
					Actively Working? Y ❒ / N ❒	If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ — Full-time student and aged 19 or older ❒ — Disabled and aged 26 or older ❒ — Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ — Full-time student and aged 19 or older ❒ — Disabled and aged 26 or older ❒ — Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ — Full-time student and aged 19 or older ❒ — Disabled and aged 26 or older ❒ — Plan Type: ❒ Medical ❒ Dental

Please check if you are using separate forms for additional dependent children ❒ — Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	
☐ **HSA: Health Savings Account**			FSA Goal Amount (Please see instructions for limits.): $
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature Samuel Sample Date 11/2/06 Employer's Signature Frank Fake Date 11/3/06

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

The following Enrollment and Change form shows **how to voluntarily terminate a member.** You may also use this example for other terminations.

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transferring To
ABC COMPANY	0000000	

Current BCBS ID #, If any	Requested Effective Date	Date of Hire	Current Dental Group #:	Dental Group #, Transferring To
999999999	07 (MM) 12 (DD) 2007 (YYYY)	MM DD YYYY		

Type of Transaction
❐ ADD ☒ CANCEL
❐ CHANGE Three digit termination code 0 4 1
❐ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction) VOLUNTARY CANCELLATION EFFECTIVE 07/12/07

❐ Open Enrollment ❐ New Hire ❐ COBRA
Change to Family ❐ Add Spouse ❐ Add Dependent
❐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
❐ Other: _____

2. Yourself (Member 1)

What products? ❐ Access Blue ❐ Blue Choice ❐ Blue Choice New England ❐ Blue Medicare Rx (Part D) ❐ Dental Blue ☒ HMO Blue ❐ HMO Blue New England ❐ Managed Blue for Seniors ❐ Medex (Group) ❐ Network Blue ❐ PPO ❐ Saver Blue

Membership Type (Medical) ☒ Individual ❐ Family
Membership Type (Dental) ❐ Individual ❐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
SAMUEL	S	SAMPLE	M	04/22/1970

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code
401 PARK DRIVE		BOSTON	MA	02215

Home Phone	Cell Phone	Email
(617) 555-0000	( )	

Social Security # (REQUIRED)[1]	Other Insurance?[2]	Other Insurance Company Name	City / State
000 000 000	Y ❐ / N ☒		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
700J00000	DR. B CROSS	BOSTON, MA	Y ☒ / N ❐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #	
Y ❐ / N ☒	MM DD YYYY	MM DD YYYY	MM DD YYYY		❐ 65+ ❐ Disabled ❐ ESRD
				Actively Working? Y ❐ / N ❐	If Retired, Date

3. Member 2

Please Check One: ❐ Spouse ❐ Domestic Partner ❐ Divorced Spouse (court ordered) Plan Type: ❐ Medical ❐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1]	Other Insurance Company Name	City / State
		Y ❐ / N ❐		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
			Y ❐ / N ❐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #	
Y ❐ / N ❐	MM DD YYYY	MM DD YYYY	MM DD YYYY		❐ 65+ ❐ Disabled ❐ ESRD
				Actively Working? Y ❐ / N ❐	If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❐ / N ❐ Full-time student and aged 19 or older ❐ Disabled and aged 26 or older ❐ Plan Type: ❐ Medical ❐ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❐ / N ❐ Full-time student and aged 19 or older ❐ Disabled and aged 26 or older ❐ Plan Type: ❐ Medical ❐ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❐ / N ❐ Full-time student and aged 19 or older ❐ Disabled and aged 26 or older ❐ Plan Type: ❐ Medical ❐ Dental

Please check if you are using separate forms for additional dependent children ❐ Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	
☐ HSA: Health Savings Account			FSA Goal Amount (Please see instructions for limits.): $
☐ FSA: Health Flexible Spending Account			Health: $
☐ FSA: Dependent Care Reimbursement Account			Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature Samuel Sample Date 6/29/07 Employer's Signature Frank Fake Date 6/29/07

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

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

Please Read the Instructions Before Filling Out This Form.

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transferring To
ABC COMPANY	0000000	

Current BCBS ID #, If any	Requested Effective Date	Date of Hire	Current Dental Group #	Dental Group #, Transferring To
999999999	06 (MM) 01 (DD) 2007 (YYYY)	MM DD YYYY		

Type of Transaction
☐ ADD ☐ CANCEL
☒ CHANGE Three digit termination code ☐☐☐
☐ TRANSFER

Remarks: (i.e., qualifying event for a new add, change to family or other instruction) CHANGE PCP FOR SUBSCRIBER

☐ Open Enrollment ☐ New Hire ☐ COBRA
Change to Family ☐ Add Spouse ☐ Add Dependent
☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
☐ Other: _____

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice ☐ Blue Choice New England ☐ Blue Medicare Rx (Part D) ☐ Dental Blue ☐ HMO Blue ☒ HMO Blue New England ☐ Managed Blue for Seniors ☐ Medex (Group) ☐ Network Blue ☐ PPO ☐ Saver Blue

Membership Type (Medical) ☒ Individual ☐ Family
Membership Type (Dental) ☐ Individual ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
SAMUEL	S	SAMPLE	M	04/22/1970

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code
401 PARK DRIVE		BOSTON	MA	02215

Home Phone	Cell Phone	Email
(617) 555-0000	( )	

Social Security # (REQUIRED)[1]	Other Insurance?[2]	Other Insurance Company Name	City / State
000 000 000	Y ☐ / N ☒		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
700J00000	DR. B CROSS	BOSTON, MA	Y ☐ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #		
Y ☐ / N ☒	MM DD YYYY	MM DD YYYY	MM DD YYYY		Actively Working? Y ☐ / N ☐	☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date

3. Member 2 Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered) Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ☐ / N ☐	Other Insurance Company Name	City / State

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
			Y ☐ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #		
Y ☐ / N ☐	MM DD YYYY	MM DD YYYY	MM DD YYYY		Actively Working? Y ☐ / N ☐	☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

Please check if you are using separate forms for additional dependent children ☐ Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	
☐ **HSA: Health Savings Account**			FSA Goal Amount (Please see instructions for limits.): $
☐ **FSA: Health Flexible Spending Account**			Health: $
☐ **FSA: Dependent Care Reimbursement Account**			Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature Samuel Sample Date 5/15/07 Employer's Signature Frank Fake Date 5/15/07

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

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

Blue Cross Blue Shield of Massachusetts
Member Underwriting Mail Stop 02-03
One Enterprise Drive
QuincyMa 02171-2125

Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child

Due to patient confidentiality, this completed form may NOT be sent via FAX

Instructions:

1. Complete **Section I**
2. Please give this form to the physician or psychologist who has firsthand knowledge of the child's condition
3. Ask the physician or psychologist to complete and **personally** sign the **Section II** of this form
4. Return the form to Member Underwriting at the address indicated above.
5. **If child is not presently covered under your BCBSMA membership, please provide us with documentation verifying the child's continuous enrollment as a dependent under your health plan(s) from the date the child would have lost coverage as a dependent had they not been disabled. We may accept, for example, documentation from an insurance company or third party that administered your previous health plan or from an employer that sponsored your previous health plan.**

Section I (please print or type)

To Be Completed by the Subscriber

Enter your name and identification number as they appear on your BCBSMA identification card.

Subscriber's name: _____ BCBSMA ID No.: _____

Subscriber's address: _____ Type of Coverage: ☐ **Individual** ☐ **Family**

_____ Telephone No.: (_____) _____

If group coverage, employer's name: _____ Group No. (if known): _____

Child's name: _____ Child's date of birth: _____/_____/_____

Child's martial status: ☐ **Single** ☐ **Married**

Does the child have their BCBSMA membership? ☐ **Yes** BCBSMA ID No.: _____ ☐ **No**

How long has this disability existed: ☐ **Since birth** ☐ **Other** (indicate approximate date of onset): _____

Is the child confined to an institution or attending school?

☐ **Yes** Date of admission _____

Name and address of institution or school: _____

☐ **No**

Is the child employed for wages?

☐ **Yes** Date of employment _____ Number of hours worked per week: _____

Name and address of child's employer: _____

☐ **No**

Is the child covered under the Federal Medicare Health Insurance program?

☐ **Yes** Medicare Category: ☐ **Disabled** ☐ **Kidney Disease**

Medicare Health Insurance Claim number: _____

Hospital Insurance (Part A) effective date: _____ Medical Insurance (Part B) effective date: _____

☐ **No**

Is child covered under Medicaid? ☐ **Yes** ☐ **No**

Is the child covered by any other insurance?

☐ **Yes** Name and address of insurance company: _____

Policyholder's name: _____

☐ **No**

I attest that to the best of my knowledge and belief the information given above is correct. I understand that enrollment for this child under my coverage may remain in force only as long as the psychological or physical disability and dependency exists, and while my coverage is of the type which may include such a dependent child. I further understand that BCBS shall have the right to require recertification as to eligibility for continuation of dependency coverage from time to time as often as BCBS may deem reasonable.

Signature of Subscriber: _____ Date: _____

For Blue Cross Blue Shield Massachusetts Office Use Only

☐ **Approved** for duration of condition or family policy

☐ **Approved on temporary basis** Effective date: _____ Termination date: _____

☐ **Denied** Reason: _____

Member Underwriting: _____ **Date:** _____ **Ext.** _____

Front

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

Section II (please print or type)

To Be Completed by the Child's Attending Physician and/or Psychologist

Patient's Name: _____ Patient's Height: _____ ft. _____ inches Weight: _____ lbs.

Diagnosis: _____

_____
(print or type)

Severity: ☐ **Mild** ☐ **Moderate** ☐ **Severe**

To your knowledge, how long has this disability existed? ☐ **Since birth** ☐ **Other** (indicate date of onset) _____

Is the patient presently under treatment?

☐ **Yes**, describe the nature of the treatment: _____
(print or type)

_____

☐ **No**

Please describe the disability at the time of the patient's 26th birthday:

Physically disabled: _____
(print or type)

_____

Psychologically disabled _____
(print or type)

_____

If the patient is developmentally delayed, what is the mental age or I.Q.? **M.A.** _____ I.Q. _____

Prognosis: _____
(print or type)

Probable future course of treatment and duration: _____
(print or type)

_____

In your professional opinion, is the patient capable of engaging in self-supporting employment? ☐ **Yes** ☐ **No**

If patient is employed, do you know what duties the patient's job requires?

☐ **Yes**, describe duties: _____

☐ **No**

In your professional opinion, will this patient ever be capable of self-support?

☐ **Yes**, indicate when: _____

☐ **No**

Remarks: _____
(print or type)

_____

_____

Physician and/or Psychologist Information

Signature of licensed Physician or Psychologist: _____ Date _____

Full Name of licensed Physician or Psychologist: _____ Tel. No.: (_____) _____
(print or type)

Office Address: _____

City: _____ State: _____ Zip: _____

PLEASE MAIL TO:

Blue Cross Blue Shield of Massachusetts
Member Underwriting Mail Stop 02-03
One Enterprise Drive
QuincyMa 02171-2125

Due to patient confidentiality, this completed form may NOT be sent via FAX

Back

Student and Dependent Eligibility Report

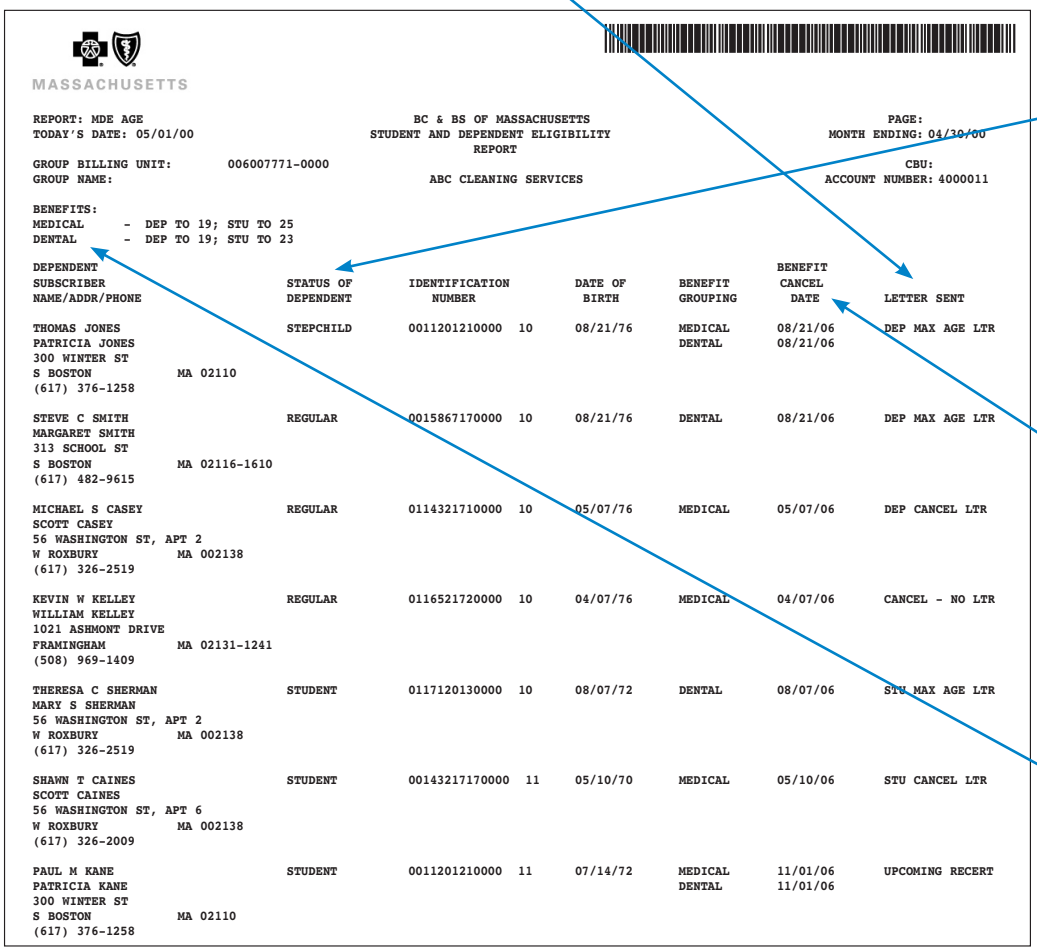
This report will show you three categories of situations:

1. Dependents nearing the regular dependent maximum age
2. Students nearing the student dependent maximum age, if applicable to your account
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 same member may appear on up to three monthly reports. The first time, the report will show "maximum age letter" sent. The second time, it will show "cancel letter." The third time, it will show "canceled—no letter" to indicate that the actual cancellation has taken place, but no letter was mailed. (See the message key on page 69.)

Please note:

If the appropriate action is taken to change the member's status at any time during the three months, the member will not appear on subsequent reports.



MASSACHUSETTS

REPORT: MDE AGE
TODAY'S DATE: 05/01/00

BC & BS OF MASSACHUSETTS
STUDENT AND DEPENDENT ELIGIBILITY REPORT

PAGE:
MONTH ENDING: 04/30/00

GROUP BILLING UNIT: 006007771-0000
GROUP NAME: ABC CLEANING SERVICES

CBU:
ACCOUNT NUMBER: 4000011

BENEFITS:
MEDICAL - DEP TO 19; STU TO 25
DENTAL - DEP TO 19; STU TO 23

DEPENDENT SUBSCRIBER NAME/ADDR/PHONE	STATUS OF DEPENDENT	IDENTIFICATION NUMBER	DATE OF BIRTH	BENEFIT GROUPING	BENEFIT CANCEL DATE	LETTER SENT
THOMAS JONES PATRICIA JONES 300 WINTER ST S BOSTON MA 02110 (617) 376-1258	STEPCHILD	0011201210000 10	08/21/76	MEDICAL DENTAL	08/21/06 08/21/06	DEP MAX AGE LTR
STEVE C SMITH MARGARET SMITH 313 SCHOOL ST S BOSTON MA 02116-1610 (617) 482-9615	REGULAR	0015867170000 10	08/21/76	DENTAL	08/21/06	DEP MAX AGE LTR
MICHAEL S CASEY SCOTT CASEY 56 WASHINGTON ST, APT 2 W ROXBURY MA 002138 (617) 326-2519	REGULAR	0114321710000 10	05/07/76	MEDICAL	05/07/06	DEP CANCEL LTR
KEVIN W KELLEY WILLIAM KELLEY 1021 ASHMONT DRIVE FRAMINGHAM MA 02131-1241 (508) 969-1409	REGULAR	0116521720000 10	04/07/76	MEDICAL	04/07/06	CANCEL - NO LTR
THERESA C SHERMAN MARY S SHERMAN 56 WASHINGTON ST, APT 2 W ROXBURY MA 002138 (617) 326-2519	STUDENT	0117120130000 10	08/07/72	DENTAL	08/07/06	STU MAX AGE LTR
SHAWN T CAINES SCOTT CAINES 56 WASHINGTON ST, APT 6 W ROXBURY MA 002138 (617) 326-2009	STUDENT	00143217170000 11	05/10/70	MEDICAL	05/10/06	STU CANCEL LTR
PAUL M KANE PATRICIA KANE 300 WINTER ST S BOSTON MA 02110 (617) 376-1258	STUDENT	0011201210000 11	07/14/72	MEDICAL DENTAL	11/01/06 11/01/06	UPCOMING RECERT

The most common status you'll see here is "regular," meaning a regular dependent, or "student." Disabled dependents will be bypassed by the maximum age process as long as we have approved the member's coverage beyond the maximum age. Thus, they'll never appear on this report, nor will they receive a letter.

This potential cancellation date is generally three months in the future. At this point, the member isn't yet canceled and may avoid cancellation if the appropriate action is taken. (For example, a member nearing age 26 may be a full-time student. Once we're notified to switch them to student status, the cancellation won't be processed.)

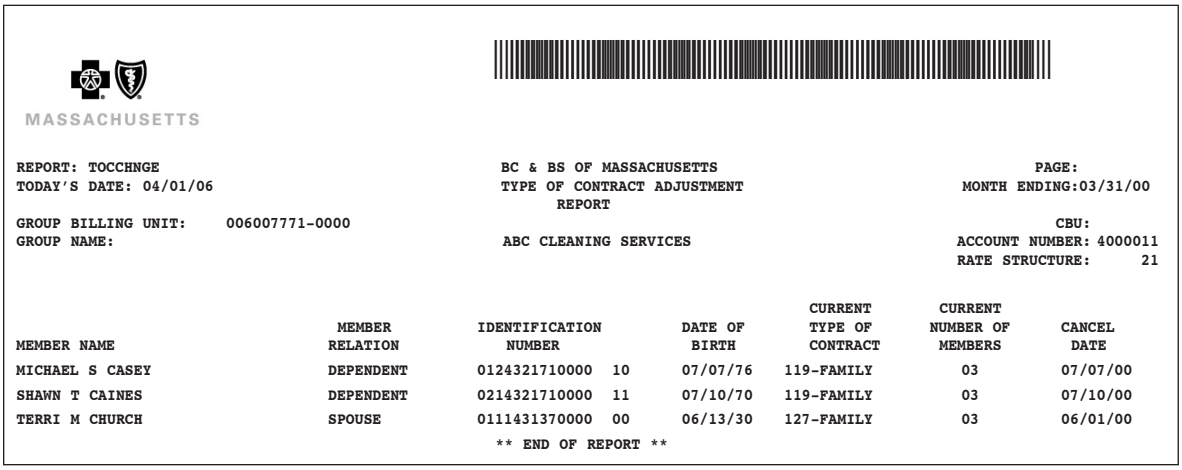
This section tells you the type of benefits the group has. It could be medical, dental, or both. It also gives the maximum age to which the member is covered for each benefit. Coverage ends on the birthday unless your group has specified otherwise. If that's the case, any variation is spelled out here.

Student and Dependent Eligibility Report *(continued)*

Message Key for Letter 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 Student Certification form 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 child's Student Certification form. 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'll 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.



MASSACHUSETTS

REPORT: TOCCHNGE
TODAY'S DATE: 04/01/06

GROUP BILLING UNIT: 006007771-0000
GROUP NAME:

BC & BS OF MASSACHUSETTS
TYPE OF CONTRACT ADJUSTMENT REPORT

ABC CLEANING SERVICES

PAGE:
MONTH ENDING:03/31/00

CBU:
ACCOUNT NUMBER: 4000011
RATE STRUCTURE: 21

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 REPORT **

Mini-COBRA Continuation Coverage Election Notice–Instructions, Notices, and Election Forms

Mini-COBRA Continuation Coverage Election

Instructions for Employers

The notice on the following pages must be sent to all beneficiaries who have qualifying events that occur on or after June 1, 2010. This notice for qualified beneficiaries includes a cover letter (summarizing some of the important specific details about their coverage should they choose to elect Mini-COBRA continuation of coverage), a general summary of their rights under the law (Notice of Right to Continue Group Health Coverage for Mini-COBRA) and a form to elect or decline continuation of coverage (Mini-COBRA Continuation Coverage Election form). Please refer to the details in the following pages, your Plan Sponsor Manual, our website for employers or other documentation we've provided that explains Mini-COBRA rights.

Before sending the notice to a qualified beneficiary, please fill in the blanks on the cover letter which include:

- the date of the letter,
- your account name,
- your address,
- the contact name of the individual at your business responsible for Mini-COBRA administration,
- the telephone number for that contact person,
- the qualified beneficiary's name in the salutation line,
- the date group coverage will end if the beneficiary does not elect,
- the date continuation of coverage will begin and end if the beneficiary elects,
- and the cost of continuation of coverage if the beneficiary elects.

On the Notice of Right to Continue Group Health Coverage for Mini-COBRA, enter the deadline for the beneficiary to submit his/her monthly premium payment.

On the Mini-COBRA Continuation Coverage Election form, enter the eligibility expiration date, account name, and contact name, address, and telephone number at the bottom of the form.

Then send the entire package to the qualified beneficiary.

Mini-COBRA Continuation Coverage Election Notice–Instructions, Notices, and Election Forms *(continued)*

Date: _____

Account name: _____

Contact name: _____

Street address: _____

City, State, Zip Code: _____

Telephone number: _____

Dear: _____

We are sending this notice to you because you had a loss of our group coverage due to certain events (see following pages) that occurred on or after June 1, 2010. However, you have the opportunity to continue with our group health plan under Massachusetts Mini-COBRA laws. Please read the information in this notice very carefully including the Notice of Right to Continue Group Health Coverage for Mini-COBRA.

To elect Massachusetts Mini-COBRA continuation coverage, follow the instructions on the following pages to complete the enclosed Mini-COBRA Continuation Coverage Election form and submit it to us.

If elected, continuation coverage will begin on _____ and can last until _____ . Continuation coverage will cost _____ . You do not have to send any payment with the Mini-COBRA Continuation Coverage Election form. However, important additional information about payment for continuation coverage after you submit your election form is included in the following pages.

If you do not elect Massachusetts Mini-COBRA continuation coverage, your coverage under the group health plan will end on _____ .

If you have any questions about this notice or your rights to continuation coverage, please contact us at the phone number above.

Sincerely,

_____

_____

Notice of Right to Continue Group Health Coverage for Mini-COBRA

What is Mini-COBRA continuation coverage?

State law gives individuals (including their spouses and/or dependents if they were covered under the group health plan) the right to continue coverage under the group health plan when the individual would otherwise have a loss of coverage due to certain qualifying events. The types of events and the length of time such a qualified beneficiary may continue coverage is shown under each situation 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 a 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.

Although you are allowed by law to continue group health coverage at your own expense, continued coverage will be terminated if:

- We cease to maintain a group health plan;
- You fail to pay the premium on time;
- You are covered under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition; or
- You are entitled to Medicare benefits.

Continuation coverage is the same coverage that the plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the Plan, including Open Enrollment and special enrollment rights.

How can you elect Mini-COBRA continuation coverage?

To elect continuation coverage, you must complete the Mini-COBRA Continuation Coverage Election form and furnish it according to the directions on the form. **Under Massachusetts Mini-COBRA law, you have 60 days after the date of this notice to decide whether you want to elect continuation coverage.** In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does Mini-COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of Mini-COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and beneficiary contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice. The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC).[1] If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at **1-866-628-4282 (TTY: 1-866-626-4282)**. More information about the Trade Act is also available at **www.doleta.gov/tradeact**.

When and how must payment for Mini-COBRA continuation coverage be made?

If you decide to continue coverage, your first payment will be due within 45 days of the date we receive your Mini-COBRA Continuation Coverage Election form. This bill will cover the time period from the date continued coverage begins through the month we receive your Mini-COBRA Continuation Coverage Election form. (Please note, therefore, that your first payment will be smaller if you make your decision within 30 days.) Once you have made the first payment for continued coverage, your premium payment must be received each month on or by the _____ day of the month to ensure that your Mini-COBRA coverage remains current. Although premium payments are due on the date shown, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. If you fail to make a monthly payment before the end of the grace period, you will lose all rights to Mini-COBRA coverage.

Keep Us Informed of Address Changes

In order to protect you and your family's rights, you should keep us informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to us for your records.

[1] Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation coverage.

Mini-COBRA Continuation Coverage Election Form

Instructions: To elect Mini-COBRA continuation coverage, complete this Mini-COBRA Continuation Coverage Election form by the eligibility expiration date shown below and return it to us. Under Massachusetts Mini-COBRA law, you have 60 days after the date of this notice to decide whether you want to elect continuation coverage.

If you do not submit a completed Mini-COBRA Continuation Coverage Election form by the eligibility expiration date, you will lose your right to elect Mini-COBRA continuation coverage. If you reject Mini-COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Mini-COBRA Continuation Coverage Election form before the eligibility expiration date.

I am aware that coverage under my current health plan can be extended for a certain length of time at my expense.

Check the appropriate boxes:

❒ Yes, I (we) elect continuation coverage in my group level health benefit program.

❒ Yes, my spouse and/or dependents were covered under my health benefit program **and** they also choose to continue coverage.

❒ Yes, my spouse and/or dependents were covered under my health benefit program BUT they choose NOT to continue coverage.

❒ No, I do not wish to continue in my current health benefit program for the following reason:

- ❒ I have other group health insurance coverage
- ❒ I have elected to convert to non-group coverage
- ❒ I am moving out of state
- ❒ This coverage is too expensive
- ❒ Other: _____

_____ _____
Signature of Beneficiary Date

_____ _____
Print Name Social Security Number

_____
Telephone Number

Current Address _____

_____

Eligibility expiration date: _____

Account name: _____

Contact name: _____

Street address: _____

City, State, Zip Code: _____

Telephone number: _____

Medicare Secondary Payer (MSP) Letter and Survey

October 2018

ABC Company
John Smith
101 Huntington Drive
Boston, MA 02199

Account Number: 0000000
Reference Number: 1234567

Dear John S. Sample:

Blue Cross Blue Shield of Massachusetts is conducting our annual surveys to satisfy federal government requirements. These surveys include:

- Medicare Secondary Payer (MSP) survey–determines the total number of employees who worked at your company in 2014
- Patient Protection and Affordable Care Act (PPACA) survey–determines the size of your company (small vs. large)
- Employer **Tax ID (EIN) collection to facilitate 1095 employee reporting obligations**

Why Is It Important to Complete these Surveys?

The Medicare Secondary Payer survey assists in determining the priority of payment for health care services. If we don't receive updated information, it may result in incorrect payments for your employees' claims and may raise issues for your account under Medicare Secondary Payer laws. For more information about this survey, please refer to important definitions on the back of the attached Frequently Asked Questions (FAQ) insert.

The Patient Protection and Affordable Care Act survey requires insurance companies to annually report our medical loss ratio (MLR) to federal regulators and pay rebates to our accounts if certain medical loss ratio targets are not met. The calculation of the medical loss ratio is based, in part, on the size of the employer groups that we insure. To calculate medical loss ratio for 2015 and determine if any rebates are due in 2016, we need to know whether your company should be categorized as a "small" or "large" employer group.

Why Do I Calculate the Number of Employees Differently for the Two Surveys?

Please note that the number of employees/group size is calculated differently for Patient Protection and Affordable Care Act purposes than it is for Medicare Secondary Payer purposes, which is why we are asking you to calculate this information differently in the two surveys.

The categorization of your company as a small or large group will also determine whether your company will be eligible for medical loss ratio rebates in 2016, that is, if Blue Cross Blue Shield of Massachusetts is required to issue rebates. For this reason, please complete the enclosed form entitled Employer Group Size Survey and indicate the average number of employees your company had in 2014, consistent with the definition provided on the survey.

If a rebate is due to your company, based on the medical loss ratio calculations, we will need you to provide the appropriate detailed reporting information, which we are required by law to retain and report to federal regulators. We will also be relying on you to distribute the rebate funds (if applicable) proportionally to your employees based on their premium contribution.

What Is the Deadline for Returning the Surveys?

To avoid receiving unnecessary follow up calls and letters, please respond to this questionnaire within the next 10 business days via one of the following:

Visit **online** and provide the information requested. You will need your Account Number and Reference Number (at top right of this page) to log in.

If you are unable to respond online, please complete the attached surveys and mail to:

Blue Cross Blue Shield of Massachusetts
P.O. Box 69006
Omaha, NE 68106

Otherwise, please complete the enclosed surveys and fax to us.

Please refer to the enclosed Frequently Asked Questions sheet if you have questions about this annual initiative, or contact us at our offices. Thank you for your assistance and your timely response.

Sincerely,

Blue Cross Blue Shield of Massachusetts
Enclosure: Surveys (Part 1 & 2), FAQs

Patient Protection and Affordable Care Act MLR Calculation Employer Group Size Survey

Employer Name: <MF28>
Account Number: <MF06> **Reference Number: <MF05>**

<MF35>

Employer Identification Number (EIN): <MF31>

Step 1. If your primary EIN (see above) is incorrect or blank, please provide the correct EIN:

_____

Note: If the primary EIN is correct, skip to the next step.

<MF06>

Step 2. This survey will determine whether your company is a "small" or "large" employer group for calculating the 2021 Medical Loss Ratio (MLR) and potential rebate. Please complete the following:

<MF02>

Please indicate the average number of employees* your company employed in 2020, as defined below for calculating the MLR, by selecting your employer size:

- ☐ Sole Proprietorship (don't count yourself or your spouse as employees (for purposes of this survey only))
- ☐ Small Employer (average of 50 or fewer employees AND at least one employee on January 1, 2021)
- ☐ Large Employer (average of 51 or more employees AND at least two employees on January 1, 2021)

<MF01>

* For purposes of counting employees and determining group size, an employer's number of employees is determined by averaging the total number of all employees employed on business days during the *preceding calendar year* [Section PHS Act §2791(e)(2) and (4)]. This includes each full-time, part-time, and seasonal employee. An employee is "any individual employed by an employer" [PHS Act §2791(d)(5)].

We'll use this employer size categorization to calculate the 2021 MLR and help determine whether your company will receive a rebate for reporting year 2021. Rebates would be issued in 2022.

We'll also rely on you to distribute rebate funds (if applicable) proportionally to your employees, according to federal guidelines.

Sign and Return: By signing and returning this form and completing this survey, you certify the accuracy of this information and confirm your understanding that we rely on your answers to calculate MLR and any associated rebate as required by federal law. **Please return the completed and signed survey within the next 10 business days.**

_____ _____ _____
Name and Title (Please Print) Signature Date

Employer Group Size Survey–Part 1

Employer Name: ABC Company Account Number: 000000 Reference Number: 1234567

<MF35>

Step 1. What is your primary Employer Identification Number (EIN)?

Step 2What was your final employee count for 2014? _____

<MF06>

Step 2a. Please indicate below, by checking the appropriate box, the employer group size that corresponds to your organization for 2014.

☐ My company employed **19 or less** full and/or part-time employees for 33+ weeks in 2014.
If your total employee count varied during the year, **please indicate the month in which your company reached the 33rd week of employing 19 or less (does not have to be consecutive weeks) and continue to Step 2:**

July ☐ August ☐ September ☐ October ☐ November ☐ December ☐

☐ My company employed **20–99** full and/or part-time employees for 20+ weeks in 2014.
If your total employee count varied during the year, **please indicate the month in which your company reached the 20th week of employing 20-99 (does not have to be consecutive weeks) and continue to Step 2:**

May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December ☐

<MF02>

☐ My company employed **100+** full and/or part-time employees for 50% or more of its regular business days in 2014.
If your total employee count varied during the year, **please indicate the month in which your company reached 50% of its regular business days employing 100+ workers and continue to Step 2:**

June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December ☐

<MF01>

Step 2. What is your current employee count for 2015? _____
Note: Please count each associate employed as one employee. This includes all employees associated with the group numbers relating to your specific account.

Step 2a. Please indicate below, by checking the appropriate box, the employer group size that corresponds to your organization for 2015.

☐ My company employed **19 or less** full and/or part-time employees for 33+ weeks in 2015.
If your total employee count varied during the year, **please indicate the month in which your company reached the 33rd week of employing 19 or less (does not have to be consecutive weeks) and continue to Reverse Side:**

July ☐ August ☐ September ☐ October ☐ November ☐ December ☐

☐ My company employed **20–99** full and/or part-time employees for 20+ weeks in 2015.
If your total employee count varied during the year, **please indicate the month in which your company reached the 20th week of employing 20-99 (does not have to be consecutive weeks) and continue to Reverse Side:**

May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December ☐

☐ My company employed **100+** full and/or part-time employees for 50% or more of its regular business days in 2015.
If your total employee count varied during the year, **please indicate the month in which your company reached 50% of its regular business days employing 100+ and continue to Reverse Side:**

June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December ☐

PLEASE COMPLETE REVERSE SIDE

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 is individual and the subscriber is turning 65; transferring the member into a retiree or Working Aged (TEFRA) group or into a nongroup 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 isn't yet cancelled but probably needs to have the membership adjusted to coincide with their 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).

MASSACHUSETTS

REPORT: AGE 65 — PAGE:
TODAY'S DATE:04/01/00 — MONTH ENDING:03/31/00

EMPLOYEES DEPENDENTS ATTAINING AGE 65 REPORT

GROUP-BU: 006007771-0000 — CBU:
GROUP NAME: ACME CLEANING SERVICES — ACCOUNT NUMBER: 4000011

ADDRESS/PHONE	MEMBER RELATION	IDENTIFICATION NUMBER		DATE OF BIRTH	TYPE OF CONTRACT	CANCEL DATE	LETTER SENT
PHILIP BARRY 101 PORTER ST E.BOSTON MA 02113-1311 (617) 325-1291	SUBSCRIBER	0123158740000	00	07/12/30	127-FAMILY	07/01/00	1ST AGE 65 LTR
TERRI M CHURCH 857 CAMBRIDGE ST CAMBRIDGE MA 02117-1214 (617) 325-1291	SPOUSE	0111431370000	01	07/13/30	127-FAMILY	07/01/00	1ST AGE 65 LTR
STEVEN HANKS 256 LYNN TERRACE DRIVE BROOKLINE MA 02137 (617) 326-6914	SUBSCRIBER	0124128540000	00	07/12/30	119-FAMILY	07/01/00	1ST AGE 65 LTR
BEVERLY B MASON 748 SHAWMUT AVE BOSTON MA 02116 (617) 482-1985	SUBSCRIBER	0114517670000	00	07/12/30	111-FAMILY	07/01/00	1ST AGE 65 LTR
RICHARD P SNOW 863 SUNNY DRIVE NATICK MA 02267-0121 (508) 623-1584	SUBSCRIBER	0124582720000	00	07/12/30	101-FAMILY	07/01/00	1ST AGE 65 LTR
KATHERINE M GILL 1600 HANCOCK ST QUINCY MA 02167 (617) 847-3125	SPOUSE	0110621250000	01	05/15/30	127-FAMILY	05/01/00	2ND AGE 65 LTR
PAUL J JONES 311 MAIN ST CAMBRIDGE MA 02138 (617) 361-2184	SPOUSE	0121067110000	01	05/12/30	111-FAMILY	05/01/00	2ND AGE 65 LTR
CHARLES SMITH 610 SLEEPER ST S BOSTON MA 02112-1211 (617) 847-1561	SUBSCRIBER	0111741330000	00	05/12/30	111-FAMILY	05/01/00	2ND AGE 65 LTR

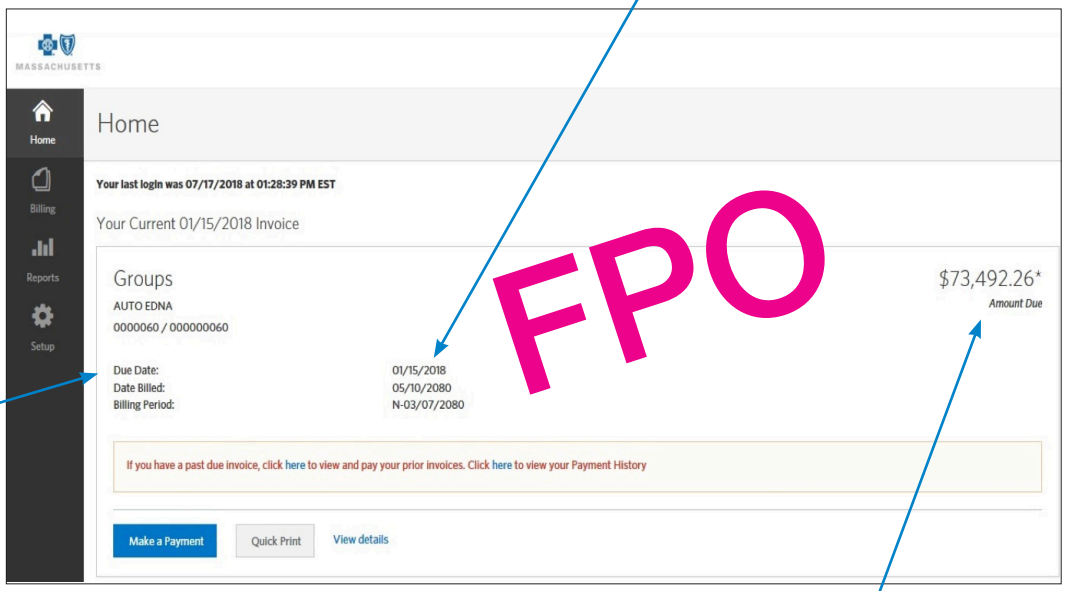
The same member may appear on up to three monthly reports. The first time, the report will show "1st age 65 letter." The second time, it will show "2nd age 65 letter." The third time, it will show "canceled—no letter" to indicate that the actual cancellation has taken place, but no letter was mailed.

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, aren't subject to the federal Working Aged (TEFRA) regulations because you have fewer 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 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.

Premium Invoice–eBilling

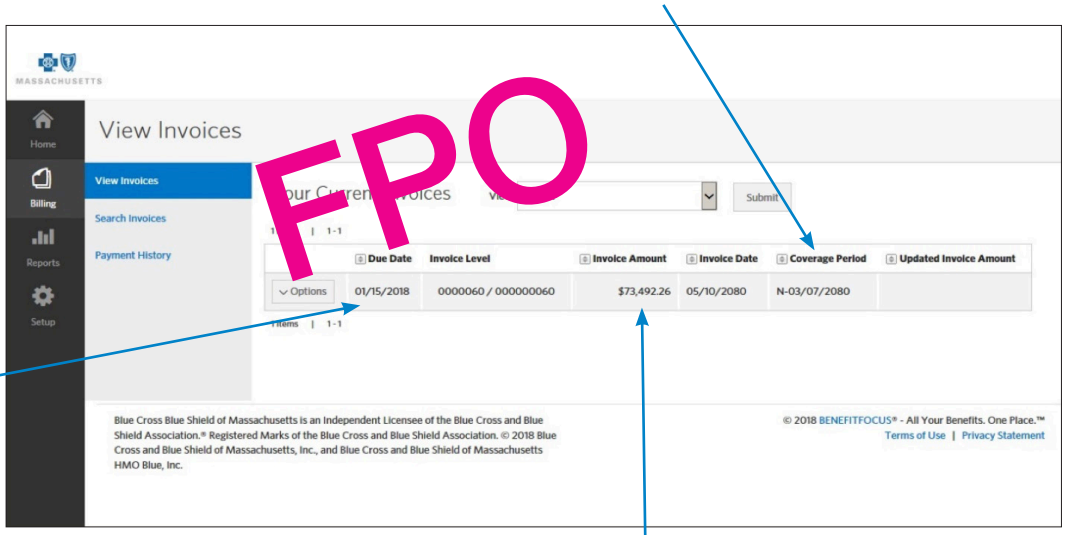
This is the date by which the premium must be paid.



Billing Period indicates coverage period for this invoice.

Total premium due shown here. Your payment should cover the total amount due.

Billing Period indicates coverage period for this invoice.

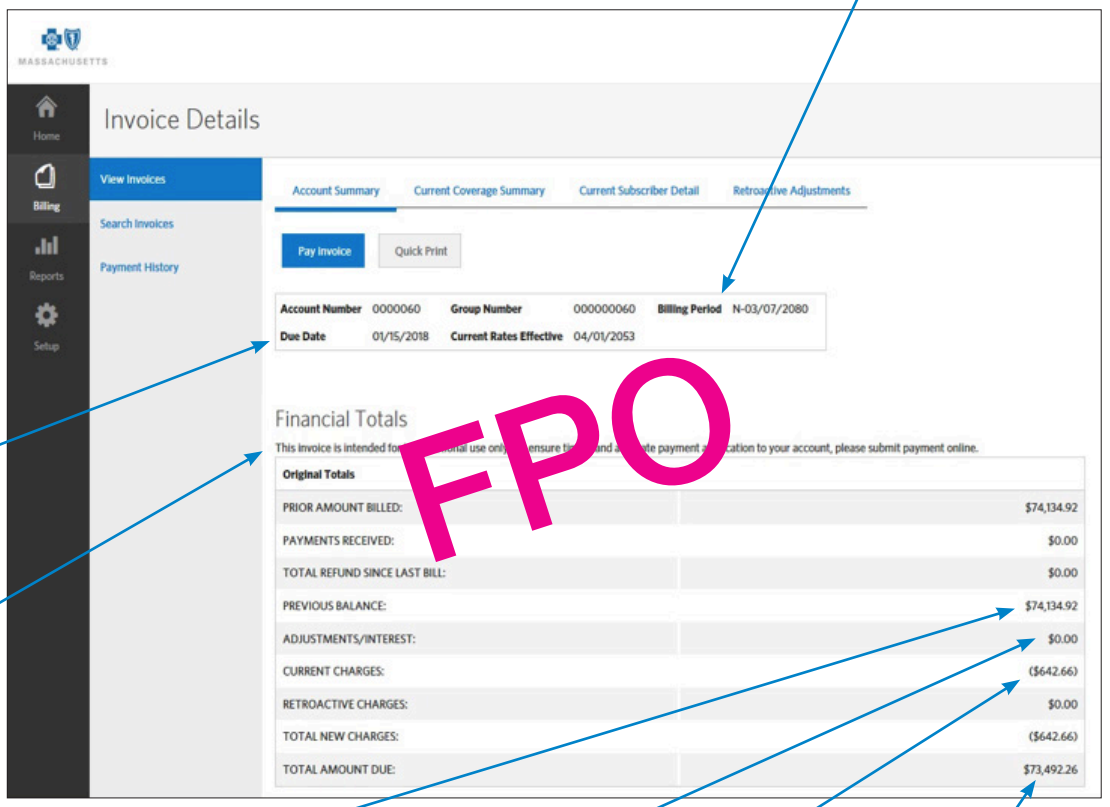


This is the date by which the premium must be paid.

Total premium due shown here. Your payment should cover the total amount due.

Premium Invoice–eBilling

Billing Period indicates coverage period for this invoice.



This is the date by which the premium must be paid.

This section is your bill history. It shows the billing and payment activity since your previous billing. Prior Amount Billed is the total amount due from your last bill.

Previous Balance
Net amount, debit or credit, of prior amount billed, payments received, and adjustments.

Interest Charges, Healthy Actions Credits, and/or other Adjustments (cash applied to or from this account) which are reflected in the **Total Amount Due** or payments to or from any of your other groups.

Total Current Charges The total amount due for the current coverage period.

Total amount due
Your payment should cover 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 edit your payment amount online through eBilling as follows:

- Select the invoice you wish to pay through the "Billing" tab
- Select the "Options" button
- Choose your bank account
- Select "Edit Payment Amount" and type the new amount
- If you have multiple group numbers you will be able to allocate funds accordingly by selecting the invoices. You will then be able to successfully submit your payment.

001607171

32-7505 (5/22)