# Table of Contents

- Introduction ........................................................................................................... 2
- Enrolling Employees in a Health Plan ................................................................. 3
- Enrolling Dependents in a Health Plan ............................................................... 10
- Changing a Member’s Status ............................................................................... 20
- Continuation of Coverage .................................................................................... 24
- When a Member Becomes Eligible for Medicare ............................................... 29
- Other Party Liability .............................................................................................. 41
- Account Billing and Premium Information ......................................................... 44
- Submitting a Claim ................................................................................................. 47
- Contract Renewal ................................................................................................. 48
- Health Insurance Portability and Accountability Act of 1996 (HIPAA) ............ 49
- Glossary .................................................................................................................. 51
- Appendix ............................................................................................................... 55
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. He or she will 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.
Enrolling Employees in a Health Plan

- Who Is Eligible for Coverage
- When an Employee Is Eligible for Coverage (Employee Qualifying Events)
- How to Enroll Employees
- How to Complete the Enrollment and Change Form
- BlueLinks™ for Employers
- BluesEnroll™
- Contact Information for Enrollment Questions
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), he or she may enroll as of the date the other coverage was canceled. Documentation in the form of a certificate of creditable coverage must include the 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 FileLink®, BlueLinks, or BluesEnroll. If you cannot send us an enrollment request through FileLink, BlueLinks, 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.
FileLink

FileLink is an application we use to systematically take in data from your payroll or HR system, compare it to our enrollment eligibility database, and make the appropriate changes, if needed.

In 2018, we have upgraded our electronic enrollment platform and will be requiring submitters to send us the standard HIPAA 5010 834 format by July 2019. Updates to our electronic processing will improve the efficiency and accuracy of member enrollment and eligibility information with:

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

To ensure a smooth transition, we’ll reach out to you with more details before your migration to the new platform begins.

Please note:
FileLink is only available to accounts with 150 or more subscribers.

BlueLinks for Employers

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

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

- **Forms & 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 eBill, 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.

Please note:
We’ll process transactions in real time from 7:00 a.m. to 8:00 p.m., Monday through Friday. For transactions completed outside of these hours, we’ll process the request as of 7:00 a.m. the following business day.

BlueLinks for Employers is located at [bluecrossma.com/employers](http://bluecrossma.com/employers).

BlueLinks for Employers doesn’t affect your use of the FileLink system. You should still continue to use FileLink for your health plan maintenance. However, you can use the BlueLinks system to make immediate updates with the Enrollment Management tool in conjunction with your regular FileLink maintenance. It’s important to note, however, that failure to update this data within your employer’s HRIS system will cause the next file transfer to overwrite any updates you made in Enrollment Management.

If you’re using BluesEnroll, contact your account executive.

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

For questions about BluesEnroll, email blue.enroll@bcbsma.com. If you’re using the Enrollment Management tool or FileLink, please call the BlueLinks Support Line at 1-800-650-9808. If you’re using BluesEnroll, contact your account executive. All others should call the Enrollment Help Line at 1-617-246-9966.

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

- Who Is Eligible for Coverage
- National Health Care Reform
- Massachusetts Health Care Reform—Updates on Dependent Eligibility
- 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
- Dependent legal ward under guardianship
- Dependent under a child support court order
- Disabled dependent child
- Child of a covered, unmarried 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, or legal guardianship
- 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
- Date specified in a child support court order
- Date the spouse or child involuntarily lost coverage under another health plan
- Date the spouse or child voluntarily canceled coverage under another health plan due to the termination of an employer’s contribution

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 did not enroll as of their initial eligibility date may enroll in the employer’s group plan as of the employer’s Open Enrollment effective date.

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 his or her 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 his or her 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
- This two-year extension period begins January 1 of the calendar year in which the dependent can no longer qualify as a dependent on the subscriber’s or spouse’s tax return

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: When does a dependent’s two-year extension of eligibility period begin?
The extension begins January 1 of the year in which the dependent can no longer be claimed as a dependent on the subscriber’s or spouse’s tax return. For example, if a 21-year-old child is claimed as a dependent on the subscriber’s tax return for tax year 2014 and isn’t claimed for the 2015 tax year, the two-year extension of eligibility period begins on January 1, 2015, and ends on December 31, 2016.

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 Eligibility 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.
There are times when a member who is enrolled in a health plan may need to change his or her membership status. Examples are name, address, and coverage 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 bluecrossma.com/employer. 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, register for BlueLinks at bluecrossma.com/employer or 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 his or her 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. If you process this type of request through BlueLinks, you must order new ID cards.

A member in a managed care plan who moves outside the enrollment area may be eligible to transfer his or her coverage. Please consult with your account service 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 he or she isn’t eligible for under an existing contract. Or, he or she misuses 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 his or her 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.com/get-blue-ma.
  - 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 or the Provider Selection Service at 1-800-821-1388 to make this change over the phone. Alternatively, the member may change his or her PCP online at bluecrossma.com/findadoctor.

- 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 his or her 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.
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

- 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 his or her former employer’s bankruptcy proceedings.

(Separate bankruptcy laws may prohibit you from terminating retiree coverage after bankruptcy is filed. You may wish to speak with an attorney regarding your bankruptcy obligation.)

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, his or her surviving spouse and dependent children, if any, are entitled to elect and pay for an additional 36 months of coverage from the date of the retiree’s death.

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 his or her 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 his or her continuation of coverage rights, we request that you cancel the member immediately from your group. Canceling the member will accomplish two things:

• It removes you from the financial burden of paying for the member’s premium while he or she is deciding whether to accept or decline the continuation of coverage.
• 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), he or she will 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, 2016. 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, 2016.

The employer notifies Mr. Smith on June 1, 2016 (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, 2016, 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, 2016), 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, 2016
Member leaves company

June 1, 2016
Qualifying event (last day of coverage)

July 31, 2016
Election date (60 days available)

September 14, 2016
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 his or her direct phone number or via our general phone number at 1-617-246-5000.

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 him or her 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, he or she is 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:

<table>
<thead>
<tr>
<th>Medicare Is Secondary Payer When:</th>
<th>Medicare Member Is</th>
<th>MSP Law</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Working Aged</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ESRD</td>
</tr>
<tr>
<td>Employer Has</td>
<td></td>
<td>20 or more employees&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Age 65+ active employee</td>
<td></td>
<td>Age 65+ active employee</td>
</tr>
<tr>
<td>Age 65+ spouse of an active employee</td>
<td></td>
<td>Age 65+ spouse of an active employee</td>
</tr>
</tbody>
</table>

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:

If Medicare member is enrolled in

- employer with 20+ employees
- employer with <20 employees
- nonemployer group
- direct-pay nongroup

and the Medicare member is

- active employee, spouse, of active employee
- retired or disabled employee, spouse, of retired or disabled employee

then

- group is the primary payer
- Medicare is the primary payer

Medicare is the primary payer
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:

*DISABILITY*

*If Medicare member is enrolled in*

- Employer/JPA with 100+ employees
- Employer/JPA with <100 employees
- Nonemployer group
- Direct-pay nongroup

*and the Medicare member is*

- Active employee, spouse or child of active employee
- Retired or disabled employee, spouse or child of retired or disabled employee

*then*

- Group is the primary payer
- Medicare is the primary payer

Medicare is the primary payer
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):

- **ESRD**

  - If member’s Medicare effective date is within the prior 30 months and the Medicare member is enrolled in
    - employer group
    - nonemployer group
    - direct-pay nongroup
      - then group is the primary payer
    - then Medicare is the primary payer
  - If member’s Medicare effective date is 31 or more months ago then Medicare is the primary payer
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, 2014. Age 65/Disability Medicare is effective February 1, 2015.
  - **Result:** Employer’s plan is the primary payer until November 30, 2016. Medicare is the primary payer December 1, 2016, 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:** Age 65/Disability Medicare is effective June 1, 2013. ESRD Medicare is effective February 1, 2014. 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, 2016. Medicare becomes the primary payer August 1, 2016, and remains so thereafter.

- When the Age 65/Disability entitlement precedes the ESRD entitlement but Medicare is the primary payer under the Working Aged (TEFRA) 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, 2013. ESRD Medicare is effective May 1, 2016.
  - **Result:** Medicare is the primary payer from March 1, 2016. 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, 2015. ESRD Medicare is effective February 1, 2016. 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, 2015. 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:

### Dual Entitlement: ESRD>Age 65

If the member’s ESRD Medicare effective date is

- within the prior 30 months

and the Medicare member is enrolled in

- employer group
- nonemployer group
- direct-pay nongroup

then

- group is the primary payer

and when the ESRD Medicare member also becomes entitled to Medicare based on Age 65 then

- group remains the primary payer for the first 30 months of ESRD Medicare entitlement, then Medicare becomes the primary payer

If the member’s ESRD Medicare effective date is

- 31 or more months ago

then

- Medicare is the primary payer

and when the ESRD Medicare member also becomes entitled to Medicare based on Age 65 then

- Medicare remains the primary payer
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.

### Dual Entitlement: ESRD > Disability

- **If the member's ESRD Medicare effective date is**
  - within the prior 30 months
  - and the Medicare member is enrolled in
    - employer group
    - nonemployer group
    - direct-pay nongroup
    - then
      - group is the primary payer
      - and when the ESRD Medicare member also becomes entitled to Medicare based on Disability
      - then
        - group remains primary payer for the first 30 months of ESRD Medicare entitlement, then Medicare becomes the primary payer

- **If the member's ESRD Medicare effective date is**
  - 31 or more months ago
  - then
    - Medicare is the primary payer
    - and when the ESRD Medicare member also becomes entitled to Medicare based on Disability
    - then
      - Medicare remains the primary payer
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:

**Dual Entitlement: Age 65+>ESRD**

*If the Aged Medicare member is enrolled in*

- **employer with 20+ employees**
  - active employee, spouse of active employee
    - group is the primary payer
      - and when the Aged Medicare member also becomes entitled to Medicare based on ESRD
        - group remains the primary payer for the first 30 months of ESRD Medicare entitlement, *then* Medicare becomes the primary payer

- **employer with <20 employees**
  - retired or disabled employee, spouse of retired or disabled employee
    - Medicare is the primary payer

- **nonemployer group**
  - Medicare is the primary payer
  - and when the Aged Medicare member also becomes entitled to Medicare based on ESRD
    - Medicare remains the primary payer

- **direct-pay nongroup**
  - Medicare is the primary payer
  - and when the Aged Medicare member also becomes entitled to Medicare based on ESRD
    - Medicare remains the primary payer
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:

**Dual Entitlement: Disability>ESRD**

*If the Disabled Medicare member is enrolled in*

- **employer/JPA with 100+ employees**
  - and the Medicare member is
    - active employee, spouse or child of active employee
      - then **group is the primary payer**
        - and when the Disabled Medicare member also becomes entitled to Medicare based on ESRD
          - then **group remains the primary payer for the first 30 months of ESRD Medicare entitlement, then Medicare becomes the primary payer**

- **employer/JPA with <100 employees**
  - then **Medicare is the primary payer**

- **nonemployer group**
  - then **Medicare is the primary payer**

- **direct pay nongroup**
  - then **Medicare is the primary payer**

- **Medicare is the primary payer**
  - and when the Disabled Medicare member also becomes entitled to Medicare based on ESRD
    - then **Medicare remains the primary payer**
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 his or her own health care coverage and is the patient, the spouse’s coverage is primary. The subscriber’s coverage of the spouse is secondary.

3. The health care plan of the parent whose birthday falls earlier in the calendar year (month/day) is primary for dependent children.

4. When guidelines 1 and 2 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 25 days before the due date. Blue Cross Blue Shield of Massachusetts is proud to offer paperless electronic bill presentment and payment. With eBill, you’ll receive an email alert as soon as your invoice is generated. eBill allows you to view and pay your invoice(s) online.

More on eBill

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

Getting started couldn’t be easier. Please go to bluecrossma.com/bluelinks-for-employers and click on Manage Your Account, then Online Billing to fill out the sign-up form. Within two business days, you’ll get a username and password to access the site. Once you log 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

Or you can 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

If you have any further questions about eBill, please contact your Blue Cross Blue Shield of Massachusetts Customer Financial Management Analyst at 1-888-751-5607 between the hours of 8:30 a.m.–4:30 p.m. ET.

See page 77-78 of the appendix for an example of an eBill 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 did not 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 will 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 between the hours of 8:30 a.m.–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 4:30 p.m. ET, or you can send us an email at payment.inquiry@bcbsma.com.
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 Forms & Documents section of the Bluelinks for Employers site at blucrossma.com/bluelinks-for-employers. Your employees may call Member Service to request claim forms.

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

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. He or she will 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 his or her 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.
BlueLinks
An umbrella term for Blue Cross Blue Shield of Massachusetts employer and broker web-based tools.

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.

eBill
A dynamic web-based tool used to manage premiums.

Emergency Care
Medical, surgical, or psychiatric care that you need immediately due to the sudden onset of a condition manifesting itself by symptoms of sufficient severity:
• 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.

Enrollment Area (applies to managed care plans)
The geographic area where each member must be a permanent resident to be covered by the plan.

FileLink
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.

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 he or she is covered under a contract.

**Managed Care**
An HMO or point-of-service plan that attempts to ensure cost-effective and quality health care through the use of a gatekeeper delivery system.

**Medicare**
The federal hospital insurance system and the supplementary medical insurance program for the aged—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)
(appplies 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)
(appplies 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 his or her health 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.
Appendix

Contents

How to Complete the Enrollment and Change Form ........................................ 57-59
Enrollment and Change Form—adding a new subscriber ................................. 60
Enrollment and Change Form—adding a new spouse ..................................... 61
Enrollment and Change Form—changing an address ..................................... 62
Enrollment and Change Form—transferring a subscriber from one group to another .... 63
Enrollment and Change Form—voluntary termination .................................. 64
Enrollment and Change Form—changing PCP ............................................. 65
Medicare Secondary Payer Compliance Form ............................................. 66
Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child Form .......................................................... 66-67
Student and Dependent Eligibility Report .................................................. 68-69
Type of Contract Adjustment Report ......................................................... 69
Mini-COBRA Continuation Coverage Election Notice ................................ 70-74
Medicare Secondary Payer (MSP) Letter and Survey ................................... 75
Employees or Dependents Attaining Age 65 Report ..................................... 76
Premium Invoice—eBill ................................................................. 77–78
**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.

**Enrollment and Change Form**

**MASSACHUSETTS**

Boston, MA 02298 or fax to 1-617-246-7531

Please mail to: P.O. Box 986001

1. To Be Filled Out by Your Employer

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Current Medical Group #:</th>
<th>Medical Group # Transferring To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current BCBS ID #, If any</th>
<th>Requested Effective Date</th>
<th>Date of Hire</th>
<th>Current Dental Group #:</th>
<th>Dental Group # Transferring To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MM DD YYYY</td>
<td></td>
<td>MM DD YYYY</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Transaction</th>
<th>Remarks (i.e., qualifying event for a new add, change to family or other instruction)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD</td>
<td></td>
</tr>
<tr>
<td>CANCEL</td>
<td></td>
</tr>
<tr>
<td>TRANSFER</td>
<td></td>
</tr>
</tbody>
</table>

2. Yourself (Member 1)

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Address</th>
<th>City / State</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security # (REQUIRED)</th>
<th>Other Insurance?</th>
<th>Other Insurance Company Name</th>
<th>Member ID Number</th>
<th>PCP ID # (see instructions)</th>
<th>Name of PCP</th>
<th>City / State</th>
<th>Is this your current PCP?</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you covered by Medicare?</th>
<th>Part A Effective Date</th>
<th>Part B Effective Date</th>
<th>Part D Effective Date</th>
<th>Medicare #</th>
<th>65+</th>
<th>Disabled</th>
<th>ESRD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
<td>MM DD YYYY</td>
<td>MM DD YYYY</td>
<td>MM DD YYYY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Member 2

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Address</th>
<th>City / State</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>P.O. Box</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security # (REQUIRED)</th>
<th>Other Insurance?</th>
<th>Other Insurance Company Name</th>
<th>Member ID Number</th>
<th>PCP ID # (see instructions)</th>
<th>Name of PCP</th>
<th>City / State</th>
<th>Is this your current PCP?</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you covered by Medicare?</th>
<th>Part A Effective Date</th>
<th>Part B Effective Date</th>
<th>Part D Effective Date</th>
<th>Medicare #</th>
<th>65+</th>
<th>Disabled</th>
<th>ESRD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
<td>MM DD YYYY</td>
<td>MM DD YYYY</td>
<td>MM DD YYYY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Dependent’s First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Sex</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security # (REQUIRED)</th>
<th>PCP ID # (see instructions)</th>
<th>Name of PCP</th>
<th>Is this your current PCP?</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(see instructions)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent’s First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Sex</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security # (REQUIRED)</th>
<th>PCP ID # (see instructions)</th>
<th>Name of PCP</th>
<th>Is this your current PCP?</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(see instructions)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Personal Savings Account

<table>
<thead>
<tr>
<th>HSA: Health Savings Account</th>
<th>Start Date</th>
<th>End Date</th>
<th>FSA Goal Amount (Please see instructions)</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FSA: Health Flexible Spending Account</th>
<th>Start Date</th>
<th>End Date</th>
<th>Health $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FSA: Dependent Care Reimbursement Account</th>
<th>Start Date</th>
<th>End Date</th>
<th>Dependent Care $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Signature (Employer & Employee)

<table>
<thead>
<tr>
<th>Employee’s Signature</th>
<th>Date</th>
<th>Employer's Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This 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 I 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.

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.

Blue Cross Blue Shield of Massachusetts is an independent Licensee of the Blue Cross and Blue Shield Association.

**Please mail to: P.O. Box 986001**

Boston, MA 02298 or fax to 1-617-246-7531
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).

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)

<table>
<thead>
<tr>
<th>What products?</th>
<th>Access Blue</th>
<th>Blue Medicare Rx (Part D)</th>
<th>HMO Blue New England</th>
<th>Managed Blue for Seniors</th>
<th>BlueChoice</th>
<th>HMO Blue</th>
<th>Network Blue</th>
<th>Membership Type</th>
<th>Membership Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Medical)</td>
<td>(Dental)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Individual</td>
<td>Individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Family</td>
<td>Family</td>
</tr>
</tbody>
</table>

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

The employee fills in his or her name, address, sex, date of birth, social security number, and phone number, as well as the provider number for the primary care provider (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.

<table>
<thead>
<tr>
<th>Your First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Sex</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address/</td>
<td>Apt.</td>
<td>City/</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>P.O. Box #</td>
<td></td>
<td>Town</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone (   )</td>
<td>Cell</td>
<td>Email</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone (        )</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Social Security # | Other Insurance? | Other Insurance | City/ State |
| (REQUIRED)        |                  | Company Name    |             |
| PCP ID #          | Name of PCP      |                |             |

If the employee selects family or other coverage, he or she enters the spouse’s information here.

#### 3. Member 2

<table>
<thead>
<tr>
<th>Please Check One:</th>
<th>Spouse</th>
<th>Domestic Partner</th>
<th>Divorced Spouse (court ordered)</th>
<th>Plan Type</th>
<th>Medical</th>
<th>Dental</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Sex</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

| Social Security # | Other Insurance? | Other Insurance | City/ State |
| (REQUIRED)        |                  | Company Name    |             |
| Phone (          )|                  |                |             |

If the employee or the employee’s spouse has other health insurance coverage, he or she should fill in the insurer’s name, city, and state.

#### If the employee or spouse is covered by Medicare, he or she 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.

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

<table>
<thead>
<tr>
<th>Dependent's First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Sex</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 any dependents or to make changes to my benefits and any restrictions that apply to my existing 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.

Blue Cross Blue Shield of Massachusetts is an independent Licensee of the Blue Cross and Blue Shield Association.

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.

---

### Enrollment and Change Form

**Please Read the Instructions Before Filling Out This Form.**

**MASSACHUSETTS**

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

<table>
<thead>
<tr>
<th>Company Name</th>
<th>ABC COMPANY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Medical Group #:</td>
<td>0000001</td>
</tr>
<tr>
<td>Current BCBS ID #:</td>
<td>70000000</td>
</tr>
<tr>
<td>Current Effective Date:</td>
<td>01/01/2007</td>
</tr>
<tr>
<td>Current Effective Date:</td>
<td>10/01/2007</td>
</tr>
<tr>
<td>Current Dental Group #:</td>
<td>0000001</td>
</tr>
<tr>
<td>Current Effective Date:</td>
<td>10/01/2007</td>
</tr>
</tbody>
</table>

**Type of Transaction**

- [ ] ADD
- [ ] TRANSFER
- [ ] CANCEL

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

- [ ] Change to Family
- [ ] New Blue
- [ ] Add Spouse
- [ ] Add Dependent
- [ ] Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
- [ ] Other...

### 2. Yourself (Member 1)

**First Name:** SAMUEL

**Middle Initial:** S

**Last Name:** SAMPLE

**Date of Birth:** 04/02/1970

**Social Security #:** 617-555-1111

**Medical Group #:** 70000000

**PCP Name:** DR. B CROSS

**Location:** BOSTON, MA

**Phone:** 617-555-1111

**City:** BOSTON

**State:** MA

**ZIP Code:** 02215

**Plan Type:** Medical

---

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

---

### 4. Your Eligible Dependents (Members 3, 4, and 5)

<table>
<thead>
<tr>
<th>Dependent's First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Sex</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time student and aged 19 or older</td>
<td>Y/N</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Full-time student and aged 19 or older</td>
<td>Y/N</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Full-time student and aged 19 or older</td>
<td>Y/N</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**Dependent's First Name:**

1. [ ]
2. [ ]
3. [ ]

**Social Security #:**

1. [ ]
2. [ ]
3. [ ]

**Plan Type:**

1. [ ] Medical
2. [ ] Dental
3. [ ] Both

---

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

---

### Enrollment and Change Form

#### 1. To Be Filled Out by Your Employer

<table>
<thead>
<tr>
<th>Company Name</th>
<th>ABC COMPANY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Member Group #:</td>
<td>00000000</td>
</tr>
<tr>
<td>Medical Group #:</td>
<td>00000000</td>
</tr>
<tr>
<td>Dental Group #:</td>
<td>00000000</td>
</tr>
</tbody>
</table>

#### Current BCBS ID #: If any

<table>
<thead>
<tr>
<th>999999999</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/30/2007</td>
</tr>
</tbody>
</table>

#### Requested Effective Date

<table>
<thead>
<tr>
<th>04/30/2007</th>
</tr>
</thead>
</table>

#### Date of Hire

<table>
<thead>
<tr>
<th>04/30/2007</th>
</tr>
</thead>
</table>

#### Current Dental Group #: If any

<table>
<thead>
<tr>
<th>00000000</th>
</tr>
</thead>
</table>

#### Date of Birth

<table>
<thead>
<tr>
<th>04/22/1970</th>
</tr>
</thead>
</table>

#### Birthday

<table>
<thead>
<tr>
<th>04/22/1970</th>
</tr>
</thead>
</table>

#### Social Security Number

<table>
<thead>
<tr>
<th>123-45-6789</th>
</tr>
</thead>
</table>

#### Type of Transaction

<table>
<thead>
<tr>
<th>ADD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CANCEL</td>
</tr>
<tr>
<td>TRANSFER</td>
</tr>
</tbody>
</table>

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

| PLEASE UPDATE NEW ADDRESS |

#### 2. Yourself (Member 1)

<table>
<thead>
<tr>
<th>Name</th>
<th>SAMUEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>SAMPLE</td>
</tr>
<tr>
<td>Gender</td>
<td>M</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>04/22/1970</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>401 PARK DRIVE</td>
</tr>
<tr>
<td>Apt #</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>BOSTON</td>
</tr>
<tr>
<td>State</td>
<td>MA</td>
</tr>
<tr>
<td>Zip Code</td>
<td>02215</td>
</tr>
<tr>
<td>Phone</td>
<td>617 555-0000</td>
</tr>
<tr>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
</tbody>
</table>

#### Social Security #

<table>
<thead>
<tr>
<th>Y / N</th>
</tr>
</thead>
</table>

#### Other Insurance

<table>
<thead>
<tr>
<th>Y / N</th>
</tr>
</thead>
</table>

#### Plan Type

<table>
<thead>
<tr>
<th>Y / N</th>
</tr>
</thead>
</table>

#### Provider

<table>
<thead>
<tr>
<th>PCP ID # (see instructions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR. B CROSS</td>
</tr>
</tbody>
</table>

#### City / State

<table>
<thead>
<tr>
<th>BOSTON, MA</th>
</tr>
</thead>
</table>

#### Are you covered by Medicare?

<table>
<thead>
<tr>
<th>Y / N</th>
</tr>
</thead>
</table>

#### Part A Effective Date

<table>
<thead>
<tr>
<th>MM DD YYYY</th>
</tr>
</thead>
</table>

#### Part B Effective Date

<table>
<thead>
<tr>
<th>MM DD YYYY</th>
</tr>
</thead>
</table>

#### Part D Effective Date

<table>
<thead>
<tr>
<th>MM DD YYYY</th>
</tr>
</thead>
</table>

#### Medicare #

<table>
<thead>
<tr>
<th>65+</th>
</tr>
</thead>
</table>

#### Actively Working?

<table>
<thead>
<tr>
<th>Y / N</th>
</tr>
</thead>
</table>

#### Disability

<table>
<thead>
<tr>
<th>Y / N</th>
</tr>
</thead>
</table>

#### ESRD

<table>
<thead>
<tr>
<th>Y / N</th>
</tr>
</thead>
</table>

#### Date Retired

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

#### 3. Member 2

#### Please Check One:

<table>
<thead>
<tr>
<th>Spouse</th>
</tr>
</thead>
</table>

#### Domestic Partner

| Divorced Spouse (court ordered) |

#### Plan Type

| Medical, Dental |

#### First Name

| M.I. |

#### Last Name

|  |

#### Social Security #

| Y / N |

#### Other Insurance

| Y / N |

#### Plan Type

| Y / N |

#### Provider

| PCP ID # (see instructions) |

#### City / State

|  |

#### Are you covered by Medicare?

| Y / N |

#### Part A Effective Date

| MM DD YYYY |

#### Part B Effective Date

| MM DD YYYY |

#### Part D Effective Date

| MM DD YYYY |

#### Medicare #

| 65+ |

#### Actively Working?

| Y / N |

#### Disability

| Y / N |

#### ESRD

| Y / N |

#### Date Retired

|  |

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

#### First Name

| M.I. |

#### Last Name

|  |

#### Date of Birth

|  |

#### Social Security #

| (REQUIRED) |

#### PCP ID # (see instructions)

| Name of PCP |

#### Plan Type

| Medical, Dental |

#### Date of Birth

|  |

#### Social Security #

| (REQUIRED) |

#### PCP ID # (see instructions)

| Name of PCP |

#### Plan Type

| Medical, Dental |

#### Date of Birth

|  |

#### Social Security #

| (REQUIRED) |

#### PCP ID # (see instructions)

| Name of PCP |

#### Plan Type

| Medical, Dental |

#### Date of Birth

|  |

#### Social Security #

| (REQUIRED) |

#### PCP ID # (see instructions)

| Name of PCP |

#### Plan Type

| Medical, Dental |

#### Date of Birth

|  |

#### 5. Personal Savings Account

<table>
<thead>
<tr>
<th>HSA: Health Savings Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date</td>
</tr>
<tr>
<td>End Date</td>
</tr>
<tr>
<td>FSA Goal Amount</td>
</tr>
<tr>
<td>Use instructions for limits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FSA: Health Flexible Spending Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date</td>
</tr>
<tr>
<td>End Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FSA: Dependent Care Reimbursement Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date</td>
</tr>
<tr>
<td>End Date</td>
</tr>
<tr>
<td>Dependent Care</td>
</tr>
</tbody>
</table>

#### Signature (Employer & Employee)

<table>
<thead>
<tr>
<th>Employee's Signature</th>
<th>SAMUEL SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>4/30/07</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer's Signature</th>
<th>Frank Fake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>4/30/07</td>
</tr>
</tbody>
</table>

---

1. **REQUITEED:** 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.

3. 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.
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.

### Enrollment and Change Form

**Company**

<table>
<thead>
<tr>
<th>Name</th>
<th>ABC COMPANY</th>
</tr>
</thead>
</table>

**Current BCBS ID #: If any**

<table>
<thead>
<tr>
<th></th>
<th>39939939939</th>
</tr>
</thead>
</table>

**Requested Effective Date**

<table>
<thead>
<tr>
<th>09/01/2007</th>
</tr>
</thead>
</table>

**Date of Hire**

<table>
<thead>
<tr>
<th>10/01/2007</th>
</tr>
</thead>
</table>

**Current Dental Group #:**

<table>
<thead>
<tr>
<th>00000001</th>
</tr>
</thead>
</table>

**Medical Group #: Transferring To**

<table>
<thead>
<tr>
<th>00000002</th>
</tr>
</thead>
</table>

**Type of Transaction**

- **ADD**
- **CANCEL**
- **TRANSFER**

**Change**

- **Three digit termination code**

<table>
<thead>
<tr>
<th>2, 4, 2</th>
</tr>
</thead>
</table>

**Remarks**

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

### Transfer from HMO to PPO

**Loss of Coverage (HIPAA Continuation of Coverage Letter Required)**

- **Other:**

#### 2. Yourself (Member 1)

**Social Security #**

<table>
<thead>
<tr>
<th>0212/1970</th>
</tr>
</thead>
</table>

**Date of Birth**

<table>
<thead>
<tr>
<th>02/04/1970</th>
</tr>
</thead>
</table>

**City / State**

<table>
<thead>
<tr>
<th>Boston, MA</th>
</tr>
</thead>
</table>

**Zip Code**

<table>
<thead>
<tr>
<th>02215</th>
</tr>
</thead>
</table>

**Name**

<table>
<thead>
<tr>
<th>SAMUEL</th>
</tr>
</thead>
</table>

**Sex**

<table>
<thead>
<tr>
<th>F</th>
</tr>
</thead>
</table>

**Plan Type:**

- **Benefit:**

**Membership Type:**

- **Individual**
- **Family**

**Current PCP:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**PCP ID #:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**Provide one of the following:**

1. **Medical**
2. **Dental**
3. **Vision**

**FPSC**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**Member 2**

**Phone:**

<table>
<thead>
<tr>
<th>(617) 555-0000</th>
</tr>
</thead>
</table>

**Cell Phone:**

<table>
<thead>
<tr>
<th>(617) 555-0000</th>
</tr>
</thead>
</table>

**Email**

<table>
<thead>
<tr>
<th><a href="mailto:Sample.EW@ROPCO.COM">Sample.EW@ROPCO.COM</a></th>
</tr>
</thead>
</table>

**Name**

<table>
<thead>
<tr>
<th>SPIDET</th>
</tr>
</thead>
</table>

**Sex**

<table>
<thead>
<tr>
<th>M</th>
</tr>
</thead>
</table>

**Plan Type:**

- **Benefit:**

**Membership Type:**

- **Individual**
- **Family**

**Current PCP:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**PCP ID #:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**Provide one of the following:**

1. **Medical**
2. **Dental**
3. **Vision**

**FPSC**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

### 3. Member 2

**Please check one:**

- **Spouse**
- **Domestic Partner**
- **Divorced Spouse**

**Medical**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**Dental**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**Verify your current PCP:**

<table>
<thead>
<tr>
<th>Y / N</th>
<th>Y / N</th>
</tr>
</thead>
</table>

**Full-time student and aged 19 or older**

<table>
<thead>
<tr>
<th>Y / N</th>
<th>Y / N</th>
</tr>
</thead>
</table>

**Disabled and aged 26 or older**

<table>
<thead>
<tr>
<th>Y / N</th>
<th>Y / N</th>
</tr>
</thead>
</table>

**Plan Type:**

- **Medical**
- **Dental**

**Member 2**

**Phone:**

<table>
<thead>
<tr>
<th>(617) 555-0000</th>
</tr>
</thead>
</table>

**Cell Phone:**

<table>
<thead>
<tr>
<th>(617) 555-0000</th>
</tr>
</thead>
</table>

**Email**

<table>
<thead>
<tr>
<th><a href="mailto:Sample.EW@ROPCO.COM">Sample.EW@ROPCO.COM</a></th>
</tr>
</thead>
</table>

**Name**

<table>
<thead>
<tr>
<th>SPIDET</th>
</tr>
</thead>
</table>

**Sex**

<table>
<thead>
<tr>
<th>M</th>
</tr>
</thead>
</table>

**Plan Type:**

- **Benefit:**

**Membership Type:**

- **Individual**
- **Family**

**Current PCP:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**PCP ID #:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**Provide one of the following:**

1. **Medical**
2. **Dental**
3. **Vision**

**FPSC**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

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

**Dependent's First Name**

<table>
<thead>
<tr>
<th>H</th>
<th>M</th>
</tr>
</thead>
</table>

**Social Security #:**

<table>
<thead>
<tr>
<th>(Required)</th>
</tr>
</thead>
</table>

**PCP ID #:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**Provide one of the following:**

1. **Medical**
2. **Dental**
3. **Vision**

**FPSC**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**Dependent's First Name**

<table>
<thead>
<tr>
<th>H</th>
<th>M</th>
</tr>
</thead>
</table>

**Social Security #:**

<table>
<thead>
<tr>
<th>(Required)</th>
</tr>
</thead>
</table>

**PCP ID #:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**Provide one of the following:**

1. **Medical**
2. **Dental**
3. **Vision**

**FPSC**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**Dependent's First Name**

<table>
<thead>
<tr>
<th>H</th>
<th>M</th>
</tr>
</thead>
</table>

**Social Security #:**

<table>
<thead>
<tr>
<th>(Required)</th>
</tr>
</thead>
</table>

**PCP ID #:**

<table>
<thead>
<tr>
<th>(see instructions)</th>
</tr>
</thead>
</table>

**Provide one of the following:**

1. **Medical**
2. **Dental**
3. **Vision**

**FPSC**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**Total # of dependents:**

<table>
<thead>
<tr>
<th>________________</th>
</tr>
</thead>
</table>

### 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:**

### Signature (Employer & Employee)

**Employee's Signature:**

<table>
<thead>
<tr>
<th>(handwritten) sample</th>
</tr>
</thead>
</table>

**Date:**

<table>
<thead>
<tr>
<th>11/3/06</th>
</tr>
</thead>
</table>

**Employee's Signature:**

<table>
<thead>
<tr>
<th>(handwritten) fake</th>
</tr>
</thead>
</table>

**Date:**

<table>
<thead>
<tr>
<th>11/3/06</th>
</tr>
</thead>
</table>
The following Enrollment and Change form shows how to voluntarily terminate a member. You may also use this example for other terminations.

<table>
<thead>
<tr>
<th>1. To Be Filled Out by Your Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name</td>
</tr>
<tr>
<td>ABO COMPANY</td>
</tr>
<tr>
<td>Current Medical Group #:</td>
</tr>
<tr>
<td>00000000</td>
</tr>
<tr>
<td>Medical Group #:</td>
</tr>
<tr>
<td>00000000</td>
</tr>
<tr>
<td>Requested Effective Date:</td>
</tr>
<tr>
<td>07/12/2007</td>
</tr>
<tr>
<td>Date of Hire:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Current Dental Group #:</td>
</tr>
<tr>
<td>DENTAL GROUP</td>
</tr>
<tr>
<td>Dental Group #:</td>
</tr>
<tr>
<td>DENTAL GROUP</td>
</tr>
<tr>
<td>Type of Transaction:</td>
</tr>
<tr>
<td>CHANGE TRANSFER</td>
</tr>
<tr>
<td>Remarks:</td>
</tr>
<tr>
<td>VOLUNTARY CANCELLATION EFFECTIVE 07/12/07</td>
</tr>
<tr>
<td>2. Yourself (Member 1)</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>SAMUEL</td>
</tr>
<tr>
<td>M.I. Last Name:</td>
</tr>
<tr>
<td>Name of PCP:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>617-555-0000</td>
</tr>
<tr>
<td>Cell:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Boston, MA</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>MA</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>02215</td>
</tr>
<tr>
<td>Social Security #:</td>
</tr>
<tr>
<td>000-000-000</td>
</tr>
<tr>
<td>Other Insurance #:</td>
</tr>
<tr>
<td>Y/N/</td>
</tr>
<tr>
<td>Other Insurance Company Name:</td>
</tr>
<tr>
<td>HealthBlue</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Boston, MA</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>MA</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>02215</td>
</tr>
<tr>
<td>Are you covered by Medicare?:</td>
</tr>
<tr>
<td>Y/N/</td>
</tr>
<tr>
<td>Part A Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Part B Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Part D Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Medicare #:</td>
</tr>
<tr>
<td>65 &amp; Disabled</td>
</tr>
<tr>
<td>If Retired, Date:</td>
</tr>
<tr>
<td>07/12/07</td>
</tr>
<tr>
<td>3. Member 2</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>SAMPLE</td>
</tr>
<tr>
<td>M.I. Last Name:</td>
</tr>
<tr>
<td>Sex:</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>04/22/1970</td>
</tr>
<tr>
<td>Social Security #:</td>
</tr>
<tr>
<td>000-000-000</td>
</tr>
<tr>
<td>Other Insurance #:</td>
</tr>
<tr>
<td>Y/N/</td>
</tr>
<tr>
<td>Other Insurance Company Name:</td>
</tr>
<tr>
<td>HealthBlue</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Boston, MA</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>MA</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>02215</td>
</tr>
<tr>
<td>Are you covered by Medicare?:</td>
</tr>
<tr>
<td>Y/N/</td>
</tr>
<tr>
<td>Part A Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Part B Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Part D Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Medicare #:</td>
</tr>
<tr>
<td>65 &amp; Disabled</td>
</tr>
<tr>
<td>If Retired, Date:</td>
</tr>
<tr>
<td>07/12/07</td>
</tr>
<tr>
<td>4. Your Eligible Dependents (Member 3, 4, and 5)</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>M.I. Last Name:</td>
</tr>
<tr>
<td>Sex:</td>
</tr>
<tr>
<td>M</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>04/22/1970</td>
</tr>
<tr>
<td>Social Security #:</td>
</tr>
<tr>
<td>000-000-000</td>
</tr>
<tr>
<td>Other Insurance #:</td>
</tr>
<tr>
<td>Y/N/</td>
</tr>
<tr>
<td>Other Insurance Company Name:</td>
</tr>
<tr>
<td>HealthBlue</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>Boston, MA</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>MA</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>02215</td>
</tr>
<tr>
<td>Are you covered by Medicare?:</td>
</tr>
<tr>
<td>Y/N/</td>
</tr>
<tr>
<td>Part A Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Part B Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Part D Effective Date:</td>
</tr>
<tr>
<td>MM DD YYYY</td>
</tr>
<tr>
<td>Medicare #:</td>
</tr>
<tr>
<td>65 &amp; Disabled</td>
</tr>
<tr>
<td>If Retired, Date:</td>
</tr>
<tr>
<td>07/12/07</td>
</tr>
<tr>
<td>Please check if you are using separate forms for additional dependent children</td>
</tr>
<tr>
<td>Total # of dependents:</td>
</tr>
<tr>
<td>5. Personal Savings Account</td>
</tr>
<tr>
<td>HSA: Health Savings Account:</td>
</tr>
<tr>
<td>Start Date:</td>
</tr>
<tr>
<td>End Date:</td>
</tr>
<tr>
<td>FSA Goal Amount (Please see instructions for limits):</td>
</tr>
<tr>
<td>FSA: Health Flexible Spending Account</td>
</tr>
<tr>
<td>Start Date:</td>
</tr>
<tr>
<td>End Date:</td>
</tr>
<tr>
<td>Health $</td>
</tr>
<tr>
<td>FSA: Dependent Care Reimbursement Account</td>
</tr>
<tr>
<td>Start Date:</td>
</tr>
<tr>
<td>End Date:</td>
</tr>
<tr>
<td>Dependent Care: $</td>
</tr>
<tr>
<td>I. Signature (Employer &amp; Employee)</td>
</tr>
<tr>
<td>Employee's Signature:</td>
</tr>
<tr>
<td>SAMPLE</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>06/28/07</td>
</tr>
<tr>
<td>Employer's Signature:</td>
</tr>
<tr>
<td>Frank Fake</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>06/28/07</td>
</tr>
</tbody>
</table>

1. REQUERD 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 Licensee of the Blue Cross and Blue Shield Association.
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.

Enrollment and Change Form

Massachusetts

Please mail to: P.O. Box 96603
Boston, MA 02298 or fax to 617-246-7531

1. To Be Filled Out by Your Employer

Company Name: ABC COMPANY

Current Medical Group #: 00000000

Medical Group #: Transferring To

Current BCBS ID #, If any: 99999999

Requested Effective Date: 06 01 2007

Date of Hire: MM DD YYYY

Current Dental Group #: 00000000

Dental Group #: Transferring To

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)

☐ Open Enrollment

☐ Change to Family

☐ Add Spouse

☐ Add Dependent

☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)

☐ Other:

CHANGE PCP FOR SUBSCRIBER

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice Rx (Part D) ☐ Blue Choice New England ☐ HMO Blue

☐ Dental Blue ☐ Managed Blue for Seniors ☐ Medex (Group)

☐ Blue Choice New England

Your First Name: SAMUEL

M.I. Last Name: SAMPLE

Home Phone: (617) 555-0000

Cell Phone: ( )

Email: 

Social Security # (REQUIRED)

Phone: ( )

City / State

Other Insurance? ☐ Y ☐ N

Company Name

City / State

Other Insurance

Company Name

City / State

PCP ID # (see instructions)

7000000000

BOSTON, MA

Is this your current PCP?

Y ☐ N ☐

Part A Effective Date

MM DD YYYY

Part B Effective Date

MM DD YYYY

Part D Effective Date

MM DD YYYY

Medicare #

65 ☐ Disabled ☐ ERSD

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)

Phone: ( )

City / State

Other Insurance? ☐ Y ☐ N ☐

Company Name

City / State

Other Insurance

Company Name

City / State

PCP ID # (see instructions)

7000000000

BOSTON, MA

Is this your current PCP?

Y ☐ N ☐

Part A Effective Date

MM DD YYYY

Part B Effective Date

MM DD YYYY

Part D Effective Date

MM DD YYYY

Medicare #

65 ☐ Disabled ☐ ERSD

If Retired, Date

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

Dependent’s First Name 1 ( )

M.I. Last Name: 

Sex: 

Date of Birth: 

Social Security # (REQUIRED)

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 2 ( )

M.I. Last Name: 

Sex: 

Date of Birth: 

Social Security # (REQUIRED)

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 3 ( )

M.I. Last Name: 

Sex: 

Date of Birth: 

Social Security # (REQUIRED)

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)

Employee’s Signature: SAMUEL SAMPLE

Date: 5/15/07

Employee’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.

Blue Cross Blue Shield of Massachusetts is an independent Licensee of the Blue Cross and Blue Shield Association.
Request for Retaining Coverage for a Psychologically or Physically Disabled Dependent Child

Section I (please print or type)

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 marital status: □ Single □ Married

Does the child have his or her BCBSMA membership? □ Yes □ 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: ____________

□ No

Name and address of child's employer: __________________________________________________________

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 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. __________________________

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

36740 (06/15) Page 1
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: _____________________________

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

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 25 may be a full-time student. Once we’re notified to switch him or her 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

**Message Key for Letter Sent Column (if applicable to your account)**

<table>
<thead>
<tr>
<th>Upcoming Recert:</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stu Recert Form:</td>
<td>Letter mailed to a parent in September with the Student Certification form enclosed. This form must be returned by October 15.</td>
</tr>
<tr>
<td>Stu Recert CXL:</td>
<td>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.</td>
</tr>
<tr>
<td>Dep Max Age Ltr:</td>
<td>Letter mailed three months before a regular dependent turns age 19.</td>
</tr>
<tr>
<td>Dep Cancel Ltr:</td>
<td>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.</td>
</tr>
<tr>
<td>Stu Max Age Ltr:</td>
<td>Letter mailed three months before a student dependent turns age 23 or age 25.</td>
</tr>
<tr>
<td>Stu Cancel Ltr:</td>
<td>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.</td>
</tr>
</tbody>
</table>

**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.
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.
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,

____________________________________________________________

____________________________________________________________

Mini-COBRA Continuation Coverage Election Notice—
Instructions, Notices, and Election Forms (continued)
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). 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 Notice—
Instructions, Notices, and Election Forms (continued)

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

Name: John Smith
Address: 123 Main Street
City: Anytown
State: Anywhere
Zip: 12345

Dear John S. Smith,

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

- Medicare Secondary Payer (MSP) survey-determines the total number of employees who work at your company in 2014
- Patient Protection and Affordable Care Act (PPACA) survey-determines the size of your company (small or large).

To help us calculate the medical loss ratio (MLR) for this year, and ensure compliance with federal law.

Why Is It Important to Complete These Surveys?

The Medicare Secondary Payer survey exists to determine the priority of payment for health care services. If we don’t receive
Medicare Secondary Payer information, Blue Cross Blue Shield of Massachusetts may be required to pay for medical
services that were paid for by Medicare.

The Patient Protection and Affordable Care Act survey ensures insurance companies are accurately tracking medical loss
ratio (MLR), which is also known as the medical benefits ratio. The MLR is the percentage of premiums insurance companies
spend on health care services for its members, versus the premiums paid by the policyholder. The survery helps Blue
Cross Blue Shield of Massachusetts determine whether to issue or retain rebates.

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

Please note that the number of employees you calculate 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:

- Your total employee count has varied during the year in the Medicare Secondary Payer survey.
- Your company is a small group in one survey, and a large group in the other.

This employer size categorization will be used to calculate the 2015 medical loss ratio (MLR), and to determine MLR
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.

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

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 50% or more of its regular business days in 2014.
- My company employed 20-99 full and/or part-time employees for 20+ weeks in 2014.
- My company employed 100+ full and/or part-time employees for 20+ weeks in 2014.

Step 2b. 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 50% or more of its regular business days in 2015.
- My company employed 20-99 full and/or part-time employees for 20+ weeks in 2015.
- My company employed 100+ full and/or part-time employees for 20+ weeks in 2015.

Why Is It Important to Complete these Surveys?

This employer size categorization will be used to calculate the 2015 medical loss ratio (MLR), and help determine
whether your company will be eligible for 2015 rebates, if any are required to be issued in 2016.

Step 3. If you are unable to respond online, please complete the enclosed surveys and mail to:

Blue Cross Blue Shield of Massachusetts

P.O. Box 69006
Omaha, NE 68106

101 Huntington Drive

John Smith

Salary $30000

By signing and returning this form (or by completing this survey), you certify the accuracy of this
information and confirm your understanding that we rely on your answers to process your claims in accordance with
Medicare Secondary Payer law and to calculate Medical Loss Ratio (MLR) and any associated rebates as required by
federal law.

**PLEASE COMPLETE REVERSE SIDE**

Name & Title (Please Print):

Signature:

Date:

This employer size categorization will be used to calculate the 2015 medical loss ratio (MLR), and to determine MLR
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.

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 50% or more of its regular business days in 2014.
- My company employed 20-99 full and/or part-time employees for 20+ weeks in 2014.
- My company employed 100+ full and/or part-time employees for 20+ weeks in 2014.

Step 2b. 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 50% or more of its regular business days in 2015.
- My company employed 20-99 full and/or part-time employees for 20+ weeks in 2015.
- My company employed 100+ full and/or part-time employees for 20+ weeks in 2015.

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.
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 his or her Medicare eligibility. Remember, we determine the cancellation date based on the Medicare eligibility date, which is the first day of the month in which the member turns 65 (unless the birthday falls on the first day of the month—then Medicare is effective on the first day of the previous month).

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.

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.
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.

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.
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 eBill 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.