Administrative Handbook

Welcome to Fallon Community Health Plan!

FCHP is one of the most experienced and innovative health care organizations in Massachusetts. With a vast network of services and facilities throughout the Commonwealth, FCHP is dedicated to providing high-quality products and services and exceptional customer care.

We are pleased to provide you with this handbook to help you administer our products. We hope you will find it informative and easy to use. Please note that the information in this handbook is based on standard plan information. Your group contract may differ in some areas.

For sales and service, please contact your account manager, who can provide you with information about premiums and rates, as well as supply you with literature, including:

- ✓ Brochures
- ✓ Copies of your group's *Member Handbook/Evidence of Coverage*
- ✓ Benefit summaries
- ✓ Annual reports
- ✓ Transaction forms
- ✓ Privacy notices
- ✓ Additional copies of our member magazine, *Healthy Communities*.

Have questions? Just ask.

For business calls: 1-800-333-2535
For Customer Service calls: 1-800-868-5200
(TDD/TTY: 1-877-608-7677)
Monday through Friday, 8 a.m. to 6 p.m.

Our Customer Service team can answer benefit questions, assist in provider selection, process health care option changes, and more.

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Fallon Community Health Plan

Based in the heart of Massachusetts, Fallon Community Health Plan is a health care services organization with a mission of *making our communities healthy.* And we take our mission very personally. After all, Massachusetts has been our home since 1977, and since then, we've been providing health care services to our family, friends and neighbors. Through our relationships with physicians and hospitals in the communities we serve, we've ensured that our members receive the highest quality of care from those they trust. Consistently rated one of the nation's top health plans, FCHP offers customized, quality products and services to match the health care needs of groups and individuals alike. With our continued commitment to improve the health and wellness of all we serve, it's comforting to know that for whatever life brings, Fallon Community Health Plan provides more. More benefits. More services. More you.

Our Web site

The Fallon Community Health Plan Web site—fchp.org—is easy to use and a great resource of valuable information for employers, members and providers. Through the Web site, members can perform simple customer service transactions, find information about plan options and benefits, look for providers, request materials, and much more. Some of the features include:

- ✓ **My FCHP**, which gives members the opportunity to manage account information and access exclusive health education and decision tools.
- ✓ Our **Personal Wellness Profile**™, designed to help FCHP members make informed decisions about their health, and their health care.
- ✓ The **Compare Hospitals tool** lets FCHP members compare hospital quality and cost for 150+ procedures at over 100 hospitals in a side-by-side comparison.
- ✓ **Find a physician**, a comprehensive provider search tool that allows FCHP members and prospective members to search for their own doctor within the FCHP networks, also allows browsers to search for doctors based on criteria such as hospital affiliation, gender, and languages spoken.
- ✓ **Healthwise Knowledgebase**, an easy to search health encyclopedia featuring information about diseases, conditions, medications and other health topics.
- ✓ **Forms library**, where commonly requested materials such as It Fits! reimbursement forms can be downloaded and printed on the spot.

And for employers, we have a secure, password-protected **Employer Tools** page. In this section, you can access tools that include:

- ✓ Online enrollment
- ✓ Secure file transfers
- ✓ Eligibility verification
- ✓ Status changes
- ✓ And more!

You can also access our employer publications, *Employer Edge* and *Eye on Government*. And we are constantly updating our on-line list of frequently asked questions that may be useful to you.

FCHP networks and products

At Fallon Community Health Plan, we know that one size does not fit all—that's why we offer three different networks for our commercial products.

FCHP Direct Care

The FCHP Direct Care network is made up of several of the Commonwealth's most cost-efficient, high-quality provider groups and community-based hospitals. Providers in this network are carefully chosen for their medical excellence, convenient patient access and innovation. Unique to the marketplace, FCHP Direct Care offers members more coordinated care and low cost.

FCHP Select Care

FCHP Select Care is an expansive network that includes physician practices, community-based hospitals and medical facilities across the Commonwealth. The network encompasses more than 17,000 providers and 50 hospitals. FCHP Select Care offers greater choice at a competitive price.

Fallon Preferred Care
An extensive national and regional network comprised of over 600,000 providers gives your employees the flexibility to receive care from any provider they wish—whether the provider is in the network or not.

Within these three networks, there are a variety of plans to choose from, including traditional copayment plans, point-of-service plans, deductible plans, and self-funded ASO/TPA plans.

FCHP also offers the following plans for individuals:

- Commonwealth Care FCHP Direct Care
- Major Medical
- FCHP MassHealth (for Medicaid eligibles)
- Summit ElderCare® (sponsored by FCHP)
- NaviCare℠

Fallon Senior Plan™
You should make your employees aware that FCHP offers health care coverage for beneficiaries of Medicare. FCHP can provide information about which Medicare group or consumer options may work best for you and your employees. Fallon Senior Plan, FCHP's Medicare Advantage plan, is offered through a special arrangement with the Centers for Medicare & Medicaid Services. Fallon Senior Plan offers plans with and without Medicare Part D prescription drug coverage. The effective date of membership transactions must follow the time frames established each year by CMS.

For information about any of these plans, call your Account Manager at 1-800-333-2535.

The Peace of Mind Program™

The Peace of Mind Program is a referral program that allows FCHP members to receive specialty care at one of the following affiliated medical centers in Boston:

- Brigham and Women's Hospital
- Children's Hospital *(Children's Hospital is a contracted hospital with FCHP Select Care, and is available to FCHP Select Care members with a PCP referral.)*
- Dana-Farber Cancer Institute
- Massachusetts General Hospital
- Tufts Medical Center

The Peace of Mind Program may be used for all specialty care except infertility services, mental health, substance abuse, chiropractic services, dental care or speech therapy. Members may not use the Peace of Mind Program for any primary care services, including internal medicine, family practice, pediatrics or obstetrics.

FCHP members must have seen an FCHP in-plan specialist in the same specialty as the Peace of Mind Program physician for the same condition within the past three months.

The Peace of Mind Program is not available to members enrolled in FCHP MassHealth, Commonwealth Care FCHP Direct Care, FCHP Independent Care, FCHP Flex Care, Fallon Preferred Care, Fallon Senior Plan, Summit ElderCare® or NaviCare℠.

Health and wellness programs

- ✓ **It Fits!** reimburses families $400 ($200 for individuals) annually to use toward a variety of healthy activities, including Weight Watchers®, gym memberships, town/school sports programs for kids and adults, ski lift tickets, and more!
- ✓ **Oh Baby!** gives participants prenatal vitamins, a child care book, a convertible car seat or breast pump, a home safety kit and more—all at no additional cost.
- ✓ **Quit to Win**—FCHP's tobacco treatment program helps members develop a stop-smoking plan that's right for them and gives them the tools they need to succeed—for free!
- ✓ **Nurse Connect** provides free 24/7 access to registered nurses by phone or through our Web site.
- ✓ **Preventive dental coverage for the entire family** with FCHP Direct Care and FCHP Select Care HMO plans.
- ✓ **Eyewear discounts** of 25% or more at contracted vendors, include frames, prescription lenses and nonprescription sunglasses.
- ✓ **Mail-order prescription service** for maintenance medications.

- ✓ **Disease care services** offer members access to several focused-care programs that emphasize the careful coordination of resources for people with certain chronic conditions.
- ✓ **Behavioral health and substance abuse services** are part of our standard benefits to promote a healthy body and a healthy mind.
- ✓ **Naturally Well** offers discounts on acupuncture, massage therapy and chiropractic care.

Enrollment

The Service Operations Department processes all adjustments to your group membership, issues membership cards, verifies eligibility, answers questions regarding eligibility and performs membership audits. All transactions (additions, deletions, changes) are made by submission of Membership Transaction Forms. Both the employer and the employee are required to sign the Membership Transaction Form.

Employer requirements

Employers subject to Massachusetts General Laws Chapter 176J (those with 1-50 eligible employees) must offer the Plan's health insurance coverage, at a minimum, to all otherwise eligible full-time employees with a normal work week of 30 or more hours; and employees not subject to M.G.L. Chapter 176J (51 or more eligible employees) must offer the Plan's health insurance coverage, at a minimum, to all otherwise eligible full-time employees with a normal work week of 35 or more hours. Employers may offer the health benefit plan to part - time employees working at least 20 hours per week provided the employer premium contribution is at least 50% of the premium for individual coverage and at least 33% of the premium for family coverage.

Adding an employee to your group contract for FCHP coverage

Fallon Community Health Plan is a health maintenance organization with no waiting periods or pre-existing condition clauses. Therefore, enrollment is limited to the qualifying events outlined in the following sections. In addition, all transactions must be submitted to FCHP within 30 days of the requested effective date.

If you wish to add an employee to your FCHP group coverage, the employee must live or work in the appropriate FCHP service area, be on your group's regular payroll and have appropriate payroll deductions made. The employee must also meet the employee requirements outlined above.

New hire

A completed FCHP application must be received by the Service Operations Department within 30 days of the employee's eligibility date—which is the date of hire plus your company's waiting period policy for benefit eligibility. Your company's waiting period policy must be on file in writing with FCHP. FCHP does not generally recognize waiting periods that exceed 90 days. Exceptions may be approved by the plan's Eligibility Review Committee to accommodate extenuating circumstances. If your company does not have a waiting period policy, FCHP recognizes the date of hire as an effective date. Two examples are listed below:

Example 1		Example 2	
Hire date:	April 1	Hire date:	April 1
Waiting period:	none	Waiting period:	30 days
Eligibility date:	April 1	Eligibility date:	May 1
Latest receipt date:	May 1	Latest receipt date:	June 1

Annual open enrollment

Transactions will be effective as of the group anniversary date and must be received by FCHP within 30 days of that date. Following are transactions that may be made during open enrollment:

- An employee who has no prior health insurance through your company (e.g., the employee did not pick up coverage at the time of hire) may enroll in FCHP.
- An employee may change from another insurance plan to FCHP.
- An employee may change his or her existing policy to add or remove family members from coverage.
- An employee may change his or her product (if applicable) by completing a transaction form.

Off-anniversary FCHP coverage changes

- Off-anniversary changes may be made if one of the following occurs:
- An eligible employee or dependent loses coverage through another source (e.g., left employment, end

of COBRA continuation or divorce). The change would be made for the termination date of the other coverage. A termination letter must be provided from the previous insurance company indicating the date coverage was lost, the reason for cancellation, the policy number and a list of individuals enrolled on the policy within 30 days of the requested effective date.

- An eligible employee, spouse or spousal equivalent has a significant change in contributions or premium rates. This change in coverage can be made only if the subscriber and family member are both covered by FCHP within 30 days of the requested effective date.
- A spouse or dependent may be added to an existing family contract for the date of a qualifying event (e.g., date of marriage or birth).
- An existing employee transfers employment to a location within the FCHP service area, or if the employee takes up residence in the FCHP service area, the employee may be treated as a new hire and offered FCHP HMO coverage. FCHP must receive the application within 30 days of the requested effective date.

Dependent coverage

Dependents may be eligible for coverage to age 26; see the "Eligible dependents" section. (Check your company's arrangement with FCHP for group eligibility.) A dependent also may be eligible to continue coverage under COBRA legislation (see "Continuation of coverage" section). The following are considered eligible for dependent coverage.

Disabled dependents

FCHP allows coverage for disabled dependents incapable of self-support due to a physical or mental handicap, provided that primary financial responsibility is assumed by the subscriber, subscriber's spouse or former spouse, and that that person has continuously established dependent coverage for the disabled individual under a prior carrier.

FCHP will forward a letter to the subscriber describing the documentation that is required for the review process, and a copy of the letter will be forwarded to the group sponsor. Each case is individually reviewed and the subscriber will be notified in writing of the decision, with a copy of that notification forwarded to the group sponsor. Disabled dependents who are reaching the age limit must undergo this same review process.

Disabled dependents are subject to periodic review of continued eligibility. Contact the Service Operations Department at 1-508-799-2100, or your account manager at 1-800-333-2535, for more information.

Eligible dependents

Most FCHP contracts cover dependents to age 26 or for two years following the end of the calendar year in which the dependent last qualified as an IRS dependent, whichever comes first. However, some employers may have different eligibility guidelines.

FCHP's approval for dependent coverage is based upon FCHP and IRS guidelines. If the dependent is a Massachusetts resident and under age 26, he or she may remain with FCHP under a family contract until he or she turns age 26, or two years after the end of the calendar year in which he or she last qualified as a dependent under IRS guidelines, whichever comes first. It is the responsibility of the subscriber to notify the Service Operations Department of any change in status.

A dependent child who would otherwise cease to be eligible due to a loss of full-time student status may remain eligible for coverage where required by Michelle's Law. Michelle's Law provides that individual and group health plans may not terminate a dependent child's health coverage because the child takes a medically necessary leave of absence from school or changes to part-time status. Certification by a physician is required. Coverage will continue for one year after the first day of the medically necessary leave of absence; or the date on which such coverage would otherwise terminate under the terms of the plan.

Recertification

Beginning when a dependent reaches age 20, during the first quarter of the calendar year, a letter and recertification form will be sent to the subscriber's home address to verify eligibility of dependent status. The form must be completed and signed by the subscriber, and returned to the FCHP Service Operations Department within 30 days. When we receive this form, we notify the subscriber by mail.

If the dependent is an eligible dependent or has not reached the age limit and it is within two years past the loss of dependent status, or is otherwise eligible under Michelle's Law, he or she will maintain FCHP coverage under a family contract.

If the form is returned stating the dependent is no longer an eligible dependent or it is not within two years past the loss of dependent status under IRS guidelines, coverage will be terminated as of midnight on March 31. A letter of termination will be sent to the subscriber.

If the form is not returned, FCHP will assume that the dependent is no longer an eligible dependent or it is not within two years past the loss of dependent status, and therefore is ineligible to remain under a family contract. Coverage will be terminated as of midnight on March 31. A letter of termination will be sent to the subscriber. If the dependent wishes to continue coverage, he or she can contact the group sponsor regarding election of COBRA benefits.

Changing an existing contract

Contract changes may be processed at times other than the anniversary date in the following instances:

Adding a child

An employee may change his or her contract to include a newborn child within 30 days of the birth, or a child of any age within 30 days of adoption. The addition of a spouse and other dependents also will be permitted at this time.

Adding a spouse

An employee may change from an individual contract to a family contract to add a spouse of the same or opposite sex as of the date of marriage. Other dependents also may be added at this time. Please indicate the date of marriage on the FCHP Membership Transaction Form within 30 days of the date of marriage. Both the employer and employee are required to sign the Membership Transaction Form.

Adding a domestic partner

Eligible employers may offer domestic partner coverage for same-sex or opposite-sex domestic partners, individually or together. These groups would be responsible for maintaining all affidavit records for auditing if necessary. Domestic partner coverage is offered to large groups only if the other insurance carriers for the same group are offering it, and domestic partner coverage is offered to all small groups.

Loss of coverage

An employee may change from an individual contract to a family contract to add a spouse or dependent who involuntarily loses coverage through another source, provided the Membership Transaction Form is received within 30 days. Both the employer and the employee are required to sign the Membership Transaction Form. Loss of coverage for voluntary cancellation does not qualify for this type of off-anniversary change. A termination letter from the other insurance company indicating the date coverage was lost is required. The letter also must include the old policy number, the effective date of the policy, the date of the termination of coverage, the reason for termination and a list of those who were covered under the policy. The effective date of coverage will be the date the other insurance was lost.

Changing from a family contract to two individual contracts

An employee may convert from a family contract to two individual contracts if the last dependent is terminated, and the spouse works for the same company and meets the eligibility requirements. The change can be made for the date the dependent was terminated, as long as a 30-day retroactivity applies.

Changing products

An employee is allowed to change to and from any FCHP product offered through your group only during open enrollment. This type of change is done through the employer, and a Member Transaction Form would need to be received by FCHP within 30 days of your anniversary date. Both the employer and the employee are required to sign the Membership Transaction Form. The change in product will take place on your group's anniversary date.

Changing physicians

If an employee or dependent wishes to change physicians within a selected product, he or she can simply call FCHP Customer Service at 1-800-868-5200, or log in to My FCHP at fchp.org and click "Change my doctor." FCHP members can change their physician at any time.

Removing employees and/or dependents from FCHP coverage

To remove employees and/or dependents from your group, a Membership Transaction Form must be completed, with the appropriate removal reason checked off and sent to the Service Operations Department within 30 days of

the requested removal date. Both the employer and the employee are required to sign the Membership Transaction Form. If your company extends coverage for any reason past the date of termination of employment, the date to which you want coverage extended should be indicated as the requested effective date on the Membership Transaction Form. Coverage is terminated at midnight on the day before the requested effective date (e.g., if the requested effective date is September 1, coverage will end at midnight on August 31.)

Duplicate coverage

A person who is covered by two FCHP policies is considered to have duplicate coverage. The policy that was in effect first may be retroactively canceled upon request, as of the effective date of the newer policy, provided a 180-day retroactivity is not exceeded.

Continuation of coverage after termination

Employees and dependents may continue membership after termination from the company in the following instances:

- An employee may be eligible to continue group coverage under COBRA or Mini-COBRA. Please refer to the sections on COBRA or Mini-COBRA for more information regarding eligibility requirements.
- If the company submits a Membership Transaction Form marked "Terminating COBRA or Mini-COBRA eligibility," a conversion option automatically will be forwarded to the subscriber. Conversion coverage begins as of the date of termination from the group coverage, and invoices are issued to the former employee on a monthly basis for pre-paid coverage. Conversion coverage is available through a full range of FCHP's health insurance plans. Information on FCHP's available health insurance plans will be sent on request to the last known address of the terminated subscriber.
- FCHP offers a direct payment plan for employees who move out of the service area and are no longer eligible for COBRA or Mini-COBRA benefits. Only emergency services will be covered under this plan. This coverage is available for 90 days and must be paid in advance. If the full 90-day period is not needed, the member will be reimbursed for the unused portion. Please make a notation in the remarks section of the Membership Transaction Form and include the correct address. Both the employer and employee are required to sign the Membership Transaction Form.
- An employee may continue to cover a divorced spouse, or s/he may remove a divorced spouse as of the date the divorce becomes final. The removed spouse may be eligible for coverage under Massachusetts state law, COBRA or Mini-COBRA. They may also be eligible for an individual FCHP health insurance plan. Once this eligibility ends, a Membership Transaction Form requesting removal due to loss of eligibility should be sent to FCHP. Both the employer and the employee are required to sign the Membership Transaction Form. FCHP will then send information on available health insurance plans to the terminated member. If the employee remarries, he or she may cover only the current spouse or the former spouse under their family contract.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that requires employers with 20 or more employees to offer a continuation of group health coverage to employees and their dependents who would otherwise lose group health coverage due to certain qualifying events, such as leaving employment or layoff. The Commonwealth of Massachusetts Chapter 297 of the Acts of 1996, among other provisions, extends the eligibility and requirements of COBRA to groups with as few as two employees (see section on Mini-COBRA).

COBRA enrollees receive the same level of group benefits as active employees. It is the employer's responsibility to notify employees and their eligible dependents of their rights under COBRA within 14 days of the qualifying event. Billing for continuation of coverage under COBRA also is the employer's responsibility. However, employers may add up to 2% to the group premium rate as an administrative charge.

FCHP COBRA coverage guidelines

Please note: These guidelines are based on FCHP's interpretation of these regulations. Consult your appropriate business advisor to determine your obligations.

- If the subscriber chooses at the time of the qualifying event to remain on the group coverage, nothing needs to be done. The subscriber will automatically remain on your FCHP group coverage. Please note that it is the employer's responsibility to collect premium payments from the former employee and forward them to FCHP. When a termination from COBRA is requested, it must be forwarded to FCHP's Service Operations Department within 30 days of the requested termination date.

- If the subscriber does not choose to remain on the group coverage or if no immediate election is made, you should remove the subscriber and dependents from your group. A termination form should be forwarded to the Service Operations Department within 30 days of the requested termination date.
- If the subscriber chooses COBRA coverage after FCHP receives a termination form, a Membership Transaction Form requesting reinstatement of the subscriber must be forwarded to the Service Operations Department as soon as the employer receives payment from the employee. Please include a notation in the remarks section stating the reason for reinstatement. COBRA coverage would be effective as of the date of termination.

COBRA time frames
If the company chooses not to administer COBRA according to the above guidelines, FCHP will require documentation of correspondence and/or payments indicating compliance with COBRA time frames below.

Please note: FCHP will not terminate a COBRA-eligible employee more than 30 days retroactively without this documentation.

It is the responsibility of the employer to notify the employee and/or dependent(s) regarding COBRA options within 14 days of the qualifying event. The employee and/or dependent(s) then has 60 days following the COBRA notification to decide to continue group coverage. The employee and/or dependent(s) then have 45 days to pay the premium to the employer or group sponsor.

Since FCHP normally offers 30-day retroactivity, a maximum total of 149 days of retroactivity will be offered for documented COBRA-related transactions that meet these guidelines.

For all COBRA-related changes, additions and terminations, please use the remarks section on the Membership Transaction Form to indicate what is being requested. When a person is terminated from COBRA, FCHP will contact the former COBRA subscriber by mail at his or her last known address to offer information regarding the member's available options.

Continuation of small group health coverage (Mini-COBRA)

Mini-COBRA is a state law that requires insurers and HMOs, such as FCHP, to provide enrollees (employees and their dependents, called "qualified beneficiaries") with the opportunity to continue to receive coverage through their small group health plan and pay group rates for certain time periods if the employee becomes ineligible for coverage for certain reasons—called "qualifying events"—described later. Small group employers are required to help with the administration of Mini-COBRA by issuing certain notices and election forms, and collecting premiums. A small group employer's responsibilities are set forth later in this section.

Mini-COBRA applies to small group health benefit plans issued to employers with two to 19 employees. However, Mini-COBRA does not apply to self-funded plans. (Unlike Mini-COBRA, COBRA benefits are mandated continuation benefits under federal law that apply to both self-funded plans and group health plans offered by employers with 20 or more employees.)

Please note: These guidelines are based on FCHP's interpretation of these regulations. Consult your appropriate business advisor to determine your obligations.

Who are qualified beneficiaries?
Qualified beneficiaries are generally individuals who are covered under a small group health benefit plan on the day before the qualifying event. Qualified beneficiaries include an employee, the spouse of an employee, and the dependent child of an employee. There are certain instances where retirees (and their family members) whose former employers are involved in bankruptcy proceedings are qualified beneficiaries and are eligible to receive mini-COBRA benefits. Please contact FCHP for further information.

What is a qualifying event?
Qualifying events are events that would cause a qualified beneficiary to lose health coverage if Mini-COBRA benefits were not available. Qualifying events include:

- Termination of the employee's employment (for reasons other than gross misconduct) or reduction in work hours.
- The death of the employee.
- The employee's new entitlement to Medicare.
- The divorce or legal separation of the employee from the employee's spouse.
- If a dependent child is no longer considered to be dependent under the terms of the small group health plan.

When does Mini-COBRA coverage end?
Mini-COBRA coverage ends in any of the following circumstances:

- The maximum time period for coverage expires (e.g., 18 months, 29 months, 36 months).
- A small group health benefit plan is no longer being provided to other similarly situated eligible employees.
- An individual becomes covered under any other health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such individual.
- Premiums are not paid in a timely manner.
- An individual becomes entitled to Medicare benefits.

When the employer must notify FCHP
The small group employer must notify FCHP within 30 days of the occurrence of any of these three qualifying events:

- Termination of the employee's employment (other than for gross misconduct) or reduction in work hours
- The death of the employee
- The employee's new entitlement to Medicare

It is not the employee's obligation to provide notice under these circumstances. Small group employers may provide notice to FCHP by completing a Membership Transaction Form.

When the employee must notify FCHP
The qualified beneficiary is responsible for notifying FCHP when either of the following qualifying events occur:

- The divorce or legal separation of the employee from the employee's spouse.
- A dependent child is no longer considered to be dependent under the terms of the small group health benefit plan.

The qualified beneficiary must notify FCHP within 60 days of the date that the divorce/legal separation occurred or that the dependent child is no longer considered dependent under the plan.

There is a special rule for qualified beneficiaries who are determined to be disabled under the Social Security Act at the time of a qualifying event involving termination or reduction in work hours. Coverage may be extended, from 18 months to 29 months, if notice of such determination is given to FCHP by the qualified beneficiary within 60 days of the date of such determination and before the end of the 18-month period. Disabled individuals are required to pay 150% of the premium for Mini-COBRA coverage after the initial 18-month period expires. These qualified beneficiaries also must notify FCHP within 30 days of the date of a final determination that they are no longer disabled.

You may help the qualified beneficiary notify FCHP by providing the employee with a notice and election form, and submitting it to FCHP. If the qualified beneficiary would like to contact FCHP directly, please provide him or her with the telephone number of the FCHP Customer Service Department (1-800-868-5200), and someone who is familiar with FCHP Mini-COBRA procedures will be able to assist him or her.

Once notified of a qualifying event, small group employers must notify qualified beneficiaries of their right to elect continuation of coverage.
FCHP requires small group employers, once they are aware of a qualifying event of any kind, to notify qualified beneficiaries of the availability of Mini-COBRA coverage (within 14 days of the date the small group employer becomes aware of the qualifying event) and tell them that they are eligible to continue their small group health care coverage. This notification sets forth the procedures that the qualified beneficiary must follow to receive this coverage, including sending their election form and paying their premiums to the small group employer, which are forwarded to FCHP. We have provided small group employers with a sample notification and election form to use.

What happens after the qualified beneficiary is notified of his or her right to continue small group health care coverage?
Once the qualified beneficiary receives the sample notice of eligibility for Mini-COBRA benefits, the qualified beneficiary has 60 days in which to elect Mini-COBRA coverage. The 60-day period runs from the later of: (a) the date on which coverage terminates by reason of the qualifying event; or (b) the date of the notice to elect Mini-COBRA. At any time during the 60-day election period, the qualified beneficiary may decide to waive his or her right to continue coverage under Mini-COBRA. If the qualified beneficiary changes his or her mind, the waiver may be revoked before the end of the election period. If the waiver is revoked, FCHP is required to provide coverage only from the date the waiver is revoked.

Election
As noted previously, the qualified beneficiary must notify the small group employer of his or her election to continue small group health care coverage within 60 days from the later of: (a) the date on which coverage terminates by reason of the qualifying event; or (b) the date of the notice to elect Mini-COBRA. The qualified beneficiary may elect to continue small group coverage by filling out the Mini-COBRA written election form, which is attached to the sample notice provided by FCHP to small group employers. The qualified beneficiary must fill out this form and return it to the small group employer. The small group employer must forward it to FCHP immediately upon receipt from the qualified beneficiary, preferably within the 60-day election period.

Premium payments
Once the qualified beneficiary has elected to continue small group health care coverage, the qualified beneficiary has additional responsibilities. Qualified beneficiaries must make their first premium payment within 45 days after electing Mini-COBRA continuation of coverage. Subsequent premium payments may, at the election of the qualified beneficiary, be made in monthly installments. Qualified beneficiaries should make every effort to pay their premium for Mini-COBRA coverage in a timely manner, as small group employers are not required to pay premium payments up front. This will ensure that Mini-COBRA coverage is not cancelled due to nonpayment of premiums. The employer must send premium payments to FCHP on time, and if their account reaches suspension status (15 days past due date), FCHP is obligated to notify subscribers, in writing, that payment has not been received. All premiums must be paid to the small group employer, who must forward the premiums to FCHP on the qualified beneficiary's behalf.

When there are multiple qualifying events
The 18-month period for which coverage is offered due to a termination or a reduction in work hours may be extended to 36 months from the date of the termination or reduction in work hours if another qualifying event (such as death, divorce, legal separation, Medicare entitlement, or dependent ceases to be dependent) occurs during the original 18-month period.

Summary of the Mini-COBRA continuation of coverage requirements:

Qualifying event	Qualified beneficiary	Who must notify FCHP	Length of time coverage must be offered
Death of an employee	Spouse, dependent child	Employer	36 months
Termination of employment (other than by reason of employee's gross misconduct)	Employee, spouse, dependent child	Employer	18 months
Reduction in hours worked by employee	Employee, spouse, dependent child	Employer	18 months
Employee becomes entitled to Medicare	Spouse, dependent child	Employer	36 months
Divorce or legal separation of the employee from his/her spouse	Spouse, dependent child	Employee or qualified beneficiary	36 months
Dependent child is no longer considered to be dependent under the small group health plan	Dependent child	Employee or qualified beneficiary	36 months

Summary of employers' responsibilities:

1. **Notification to FCHP that certain qualifying events have occurred.** Small group employers must notify FCHP within 30 days of the occurrence of any of the following qualifying events: (1) the termination or reduction in an employee's work hours; (2) the death of the employee; or (3) the employee becomes entitled to Medicare.
2. **Notification to qualified beneficiaries of their right to continue coverage under Mini-COBRA.** Small group employers must provide the sample notice and election form to the qualified beneficiary within 14 days of becoming aware of a qualifying event of any kind. Small group employers must forward the qualified beneficiary's notice and election form to FCHP immediately upon receipt from the qualified beneficiary.

3. **Administration of premium payments.** Small group employers must collect the Mini-COBRA coverage premiums from employees and forward the premiums to FCHP within 15 days of the due date, which is the first day of the covered period.
4. **Provision of FCHP's contact information.** If the qualified beneficiary does not know how to contact FCHP directly, small group employers must provide him/her with the FCHP Customer Service Department telephone number, 1-800-868-5200.

Summary of qualified beneficiaries' responsibilities:

1. **Notification.** The qualified beneficiary must notify FCHP within 60 days of the date a divorce/legal separation occurred or a dependent child is no longer considered dependent under the plan.
2. **Election.** The qualified beneficiary must notify the small employer of his/her election to continue small group health coverage within 60 days from the later of: (1) the date on which coverage terminates under the small group health plan by reason of the qualifying event; or (2) the date of the notice to elect Mini-COBRA.
3. **Premium payments.** Qualified beneficiaries must make their first premium payment to their small group employer within 45 days after electing Mini-COBRA continuation of coverage. Subsequent premium payments may, at the election of the qualified beneficiary, be made in monthly installments and also are paid to the small group employer.

Questions? Small group employers with questions regarding Mini-COBRA coverage should contact Fallon Community Health Plan's Group Services Department at 1-800-333-2535.

1099-HC proof of minimum creditable coverage

Massachusetts law requires residents over the age of 18 to show proof of minimum creditable coverage on their income taxes. Residents that do not show proof of health care coverage may be subject to losing their personal state income tax exemption. **FCHP will mail subscribers an informational 1099-HC form by January 31st, which should be used to complete the Schedule HC tax form.** Dependents over the age of 18 filing separately can use the information from the subscriber's 1099-HC form to complete their state filing. Additional copies of a subscriber's 1099-HC form issued by FCHP can be obtained by contacting our Customer Service Department at 1-800-868-5200, Monday through Friday from 8 a.m. to 6 p.m. Due to HIPAA privacy regulations, forms can only be requested by the subscriber.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a federal law that was passed to ensure that employees who switch jobs can access health care coverage, regardless of their medical status or that of their dependents. HIPAA applies to all group health plans with two or more participants who are current employees.

Since FCHP is a federally qualified HMO, there are no waiting periods or pre-existing condition clauses. Therefore, enrollment is limited to certain qualifying events described in this handbook. In accordance with HIPAA regulations, off-anniversary special enrollments will be allowed for loss of coverage from another source. Special enrollment provisions do not apply if the individual loses the coverage as a result of nonpayment of premiums or for cause. Special enrollment rights also exist for new dependents as of the date of the qualifying event. All special enrollment requests must be received by FCHP within 30 days of the qualifying event. Documentation may be required to determine eligibility.

Also, in accordance with HIPAA, FCHP will automatically issue Certificates of Creditable Coverage upon receipt of a member termination from FCHP coverage, unless otherwise directed by the employer. The certificate will be sent to the last known address of the subscriber. The certificate will include information regarding dates of coverage for all members on the contract at the time that it was terminated. Some employers may prefer to take responsibility for issuing Certificates of Creditable Coverage. If you do not want FCHP to issue these certificates for your group, simply send a letter to your group representative requesting this arrangement. Your letter should indicate that you will be responsible for complying with this regulation for your insureds. FCHP will keep a copy of the letter on record for auditing purposes.

Please note: These guidelines are based on FCHP's interpretation of these regulations. Consult your appropriate business advisor to determine your obligations.

Premium billing and collections

The Premium Billing and Collections Department processes all premium invoices and payments, answers questions regarding payments, monitors all group rates, issues late notices, imposes cancellations for nonpayment, collects unpaid premiums and performs premium reconciliations.

Group billing and premium payments

FCHP is a prepaid plan. Payment is due by the due date on your bill. Each invoice is produced approximately 20 days prior to the due date. It reflects all membership transactions and payments processed up to the day the invoice is generated. If your Membership Transaction Forms are received and processed after this date, those transactions will appear on your next bill. If the adjustment does not appear on your next bill, please contact your Account Manager at 1-800-333-2535. For any other questions you may have about your bill, call the Premium Billing Department and ask for the premium billing representative listed on your bill.

Please note: if you have a broker of record, he/she may be eligible to receive a commission and/or bonus based on the amount of premium paid. FCHP/FHLAC will make specific commission information available on request.

Where to send payments

Please include your Fallon Community Health Plan group number on your check and make checks payable to Fallon Community Health Plan. Your premium payment, accompanied by the top portion of your bill, should be sent to:

Fallon Community Health Plan
P.O. Box 55472
Boston, MA 02205-5472

Payments must be received by the "Please pay on or before" date printed on your invoice to have an accurate or current balance reflected on your next bill. If payments are returned for insufficient funds, you may be required to make future payments by certified check or money order.

Calculation of daily rate for retroactivity

The daily rate for retroactivity is calculated based on the number of days in your billing period. For example, January 1 through January 31 is 31 days. To obtain the daily rate, divide the monthly premium by 31. April 5 through May 4 is 30 days. Divide the monthly premium by 30 to get a daily rate. Contact the Premium Billing Department with any questions regarding this calculation, and ask for the representative listed on your invoice.

Split billing premium calculation

Most groups have a daily pro-ration of premium. Some groups may have a split billing premium calculation arrangement. (Some benefits administrators refer to this as the "wash" method.) To request a split billing arrangement, contact your Account Manager at 1-800-333-2535.

How does split billing work?

If a subscriber's coverage becomes effective on or before the 15th of the month, premium is owed for the entire month. If a subscriber's coverage becomes effective on or after the 16th, no premium is owed for that month. Likewise, if a subscriber's cancellation is effective on or before the 15th of the month, no premium is owed for that month. If the cancellation is effective on or after the 16th of the month, the entire month's premium will be charged.

FCHP collections policy

Because Fallon Community Health Plan is a prepaid plan, payment is due by the due date on your bill. If payment is received after this date, the following collection schedule and policies will apply. **Please note:** FCHP's collection schedule and policies for claims suspension and cancellation for nonpayment are in compliance with Massachusetts regulation 940 CMS 9.00, which became effective on March 1, 1996.

Missed payments

If payment is:

- 15 days past the due date, your group coverage will be suspended as of the "paid-to-date" and you will receive a "Notice of Past Due Balance." (Note: "paid-to-date" is the date through which the premium is paid. All premium payments are applied to the oldest unpaid balances.)
- 30 days past the due date, coverage will be canceled, a group cancellation letter will be sent to you and

"Notice of Coverage" cancellation letters with options to purchase conversion coverage will be sent to the home addresses of all subscribers in your group. (February cancellations will occur after month's end.)

- Received on or after the 31st day past the due date, you must apply to the plan for reinstatement. Contact the Premium Billing and Collections Department for details on this process.
- 60 days past the due date, your account will be referred for collection of outstanding amounts.

Claims suspension
If payment is not received by 15 days past the due date, FCHP will suspend payment of claims until your payment is received or until the group coverage is canceled. Suspensions will be removed only after receipt of the total amount due. FCHP reserves the right to cancel any group which is placed in suspension three times in 12 months.

Cancellation for nonpayment
If payment is not received by 30 days past the due date, FCHP will cancel your group coverage as of the date for which premiums have been paid. If your group coverage is canceled for nonpayment, you may apply for reinstatement within 30 days. Otherwise, there will be a 12-month waiting period before your contract can be rewritten.

Reinstatements
A written request is required for reinstatement of an account. Please send requests for reinstatement to Premium Billing and Collections at the following address:

Fallon Community Health Plan
Attn: Premium Billing
10 Chestnut St., 2nd floor
Worcester, MA 01608

FCHP charges a reinstatement fee for groups canceled for nonpayment. The fee is non-negotiable, and is calculated at 2% of the entire amount owed for reinstatement. The entire amount owed for reinstatement includes all past due and currently billed premium (for a future due date).

Employees with FCHP coverage in effect as of the cancellation date may access a 60-day conversion plan, as well as information regarding a full range of FCHP's health insurance plans for individuals. If they wish to choose this coverage, a written request from the employee must be sent to the plan within 60 days of the date of the cancellation letter. The conversion privilege will not be available to employees whose FCHP coverage became effective on or after the cancellation date.

The 60 days of conversion coverage will be at the same cost and coverage level as previously in effect for your group. Information regarding a full range of FCHP's health insurance plans will then be offered to each subscriber. Information on FCHP's available health insurance plans will be provided to all subscribers terminated for all other involuntary reasons. If subscribers choose not to purchase conversion coverage, they—and any covered dependents—will not be covered for any services received after the cancellation date.

Claims

The FCHP Claims Department is responsible for prompt and accurate claims payment in accordance with regulatory and contractual requirements.

Member reimbursements

If your employee paid for a covered service, the following information should be submitted within six months of the date of service:

- Patient's name
- Patient's date of birth
- Proof of payment (e.g., front and back of canceled check or credit card receipt)
- Bill or statement from provider showing:
    - Patient's name
    - Patient's date of birth
    - Date of service
    - Procedure code (except for prescriptions)
    - Diagnosis code (except for prescriptions)
    - Amount billed
    - Receipt showing medication and amount dispensed (only for prescriptions)

This information should be mailed to:

Fallon Community Health Plan
Attn: Claims
P.O. Box 15121
Worcester, MA 01615-0121

Other insurance

All claims are researched for third-party involvement. FCHP has the right to obtain reimbursement on workers' compensation and subrogation (injury) cases that may result in a liability claim. Also, FCHP has the right to coordinate benefits where there is additional insurance coverage. Members must provide FCHP with information and assistance in retrieving these repayments and may be contacted to supply necessary information. If you have any questions regarding coordination of benefits, please call 1-508-368-9196 and we will be happy to assist you.

Benefits may vary by employer, plan or product.
Weight Watchers is a registered trademark of Weight Watchers International, Inc.

10 Chestnut St. ■ Worcester, MA 01608
1-800-868-5200 (TDD/TTY: 1-877-608-7677)

fchp.org

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