

COMPANY INFORMATION

COMPANY NAME		TAX ID #	SIC CODE
COMPANY ADDRESS			
CITY		STATE	ZIP CODE
PHONE	FAX		WEB SITE
BILLING ADDRESS <input type="checkbox"/> SAME AS ABOVE			
CITY		STATE	ZIP CODE
IS THE GROUP A <input type="checkbox"/> CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> OTHER (Please specify) _____			
SUBSIDIARIES OR AFFILIATES TO BE COVERED AND LOCATIONS			
TOTAL NUMBER OF EMPLOYEES EMPLOYED _____ FULL-TIME _____ PART-TIME _____		HOW MANY WERE EMPLOYED 12 MONTHS AGO? _____	
<p>THE INFORMATION BELOW IS REQUIRED FOR MEDICARE SECONDARY PAYER (MSP) REPORTING: THE TOTAL NUMBER OF CURRENT EMPLOYEES WHO RECEIVE WAGES, TIPS, OR OTHER COMPENSATION (REFER TO LINE 1 OF YOUR MOST RECENT FEDERAL TAX RETURN FORM 941 OR 944) _____ (INCLUDES FT, PT, SEASON, NEW HIRE) AS OF THIS DATE _____ (MM/DD/YY)</p>		<p>DO YOU CURRENTLY HAVE A HEALTH REIMBURSEMENT ARRANGEMENT (HRA), FLEXIBLE SPENDING ACCOUNT (FSA), OR HEALTH SAVINGS ACCOUNT (HSA)? Check all that apply <input type="checkbox"/> HRA <input type="checkbox"/> FSA <input type="checkbox"/> HSA <input type="checkbox"/> None</p> <p>IF YES, HOW MUCH DO YOU, AS THE EMPLOYER, CONTRIBUTE ANNUALLY? \$ _____ or % _____</p> <p>WHO IS THE THIRD PARTY ADMINISTRATOR? <input type="checkbox"/> ULTRABENEFITS <input type="checkbox"/> OTHER (Please specify) _____</p>	

CONTACT INFORMATION

EXECUTIVE/OWNER	TITLE
PHONE	E-MAIL
BILLING CONTACT	TITLE
PHONE	E-MAIL
BENEFITS ADMINISTRATOR	TITLE
PHONE	E-MAIL



HEALTH PLAN DESIGN

TO BE COMPLETED BY FALLON COMMUNITY HEALTH PLAN AND AUTHORIZED BY THE EMPLOYER.

PLAN NAME			
BENEFITS	DETAILS	BENEFITS	DETAILS
OFFICE VISITS		CHIROPRACTIC (HMO)	
SPECIALIST VISITS		MANUAL MANIPULATION OF THE SPINE (PPO)	
PRESCRIPTIONS		OUT-OF-POCKET MAXIMUM	
EMERGENCY ROOM		SAME DAY SURGERY	
INPATIENT HOSPITAL		IMAGING	
DIAGNOSTIC SERVICES		OTHER	
RATES:			
<input type="checkbox"/> FCHP DIRECT CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP SELECT CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP PREFERRED CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP STEWARD COMMUNITY CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP TIERED CHOICE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____

PLAN NAME			
BENEFITS	DETAILS	BENEFITS	DETAILS
OFFICE VISITS		CHIROPRACTIC (HMO)	
SPECIALIST VISITS		MANUAL MANIPULATION OF THE SPINE (PPO)	
PRESCRIPTIONS		OUT-OF-POCKET MAXIMUM	
EMERGENCY ROOM		SAME DAY SURGERY	
INPATIENT HOSPITAL		IMAGING	
DIAGNOSTIC SERVICES		OTHER	
RATES:			
<input type="checkbox"/> FCHP DIRECT CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP SELECT CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP PREFERRED CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP STEWARD COMMUNITY CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP TIERED CHOICE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____

PLAN NAME			
BENEFITS	DETAILS	BENEFITS	DETAILS
OFFICE VISITS		CHIROPRACTIC (HMO)	
SPECIALIST VISITS		MANUAL MANIPULATION OF THE SPINE (PPO)	
PRESCRIPTIONS		OUT-OF-POCKET MAXIMUM	
EMERGENCY ROOM		SAME DAY SURGERY	
INPATIENT HOSPITAL		IMAGING	
DIAGNOSTIC SERVICES		OTHER	
RATES:			
<input type="checkbox"/> FCHP DIRECT CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP SELECT CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP PREFERRED CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP STEWARD COMMUNITY CARE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____
<input type="checkbox"/> FCHP TIERED CHOICE	INDIVIDUAL _____	EMPLOYEE AND SPOUSE _____	EMPLOYEE AND CHILD _____

FCHP Direct Care, FCHP Steward Community Care and FCHP Tiered Choice provide access to networks that are smaller than the FCHP Select Care network. In these plans, members have access to network benefits only from the providers in their respective network. Please consult the respective provider directory—paper copies can be requested by calling our Customer Service Department at 1-800-868-5200—or visit the provider search tool at fchp.org to determine which providers are included in FCHP Direct Care, FCHP Steward Community Care and FCHP Tiered Choice.

FCHP Tiered Choice members have access to network benefits only from the providers in FCHP Tiered Choice, and may pay different levels of copayments, coinsurance and/or deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a provider's benefit tier annually on January 1.

HEALTH PLAN INFORMATION

EFFECTIVE DATE:

PLAN YEAR CALENDAR YEAR

ARE DOMESTIC PARTNERS COVERED? YES NO

WAITING PERIOD

EMPLOYER CONTRIBUTION (%)

EMPLOYEE _____ TWO PERSON _____ PARENT/CHILD _____ FAMILY _____ OTHER _____

WILL YOUR GROUP ALSO OFFER COVERAGE THROUGH ANOTHER GROUP HEALTH PLAN? YES NO
IF YES, NAME OF THE OTHER CARRIER(S)

MEDICAL INFORMATION

ARE YOU AWARE OF ANY EMPLOYEES AND/OR DEPENDENTS WHO HAVE INCURRED MEDICAL COSTS OF MORE THAN \$25,000.00 IN THE PAST YEAR?

NO YES

IF YES, PLEASE PROVIDE DETAILS.

ARE YOU AWARE OF ANY EMPLOYEES THAT ARE NOT ACTIVELY AT WORK, DISABLED, OR MEDICALLY CONFINED DUE TO INJURY AND ILLNESS?

IF YES, PLEASE EXPLAIN THE CONDITION, TREATMENT, AND EXPECTED RETURN TO WORK DATE. NO YES

ARE YOU AWARE OF ANY DEPENDENTS THAT ARE DISABLED, OR MEDICALLY CONFINED DUE TO INJURY OR ILLNESS? NO YES

IF YES, PLEASE PROVIDE DETAILS.

BROKER INFORMATION

FALLON COMMUNITY HEALTH PLAN REQUIRES BROKERS TO FULLY DISCLOSE TO THEIR CURRENT AND PROSPECTIVE CLIENTS ALL COMMISSIONS AND FEES PAYABLE TO THE BROKER BY FCHP IN CONNECTION WITH THE SALE OF PROPOSED GROUP INSURANCE COVERAGE(S) AND SERVICES.

PRIMARY BROKER NAME

BROKER AGENCY

SECONDARY BROKER NAME

SECONDARY BROKER AGENCY

COMMISSION SPLIT (IF APPLICABLE) 50/50 70/30 60/40 80/20

COMMISSION TYPE

FCHP SALES EXECUTIVE SIGNATURE _____ DATE _____

EMPLOYER SIGNATURE _____ DATE _____

My signature above certifies that the above information is correct to the best of my knowledge. I also acknowledge acceptance of the rates and the corresponding designs listed as well as the Group Service Agreement. Group coverage will become effective only upon FCHP's acceptance of this application and payment of the required premium or fees at rates FCHP determines. Once approved, the effective date of coverage will be the effective date mutually agreed upon between FCHP and the employer, or the date the required number of employees who are to contribute to the cost of the coverage have enrolled, whichever is later.

Fallon Health & Life Assurance Company, Inc. is a wholly owned subsidiary of Fallon Community Health Plan.

Fallon Community Health Plan Group Service Agreement

WHEREAS the Fallon Community Health Plan, Inc. (FCHP; the Plan), a nonprofit health maintenance organization licensed under Massachusetts General Laws, Chapter 176G, and federally qualified under Public Law 93-222 provides health maintenance coverage for its members, and

WHEREAS the Employer wishes to make available to its employees health maintenance coverage as authorized by Massachusetts General Laws, Chapter 176G, and Public Law 93-222 through the Plan.

THEREFORE, by execution of this Group Service Agreement (the Agreement), the Plan and the Employer agree:

Availability of coverage. That the Employer shall make available to its eligible employees health maintenance coverage through the Plan.

Eligibility for membership. That eligibility for membership is the same for the Plan as for any existing health benefits program offered by the Employer, unless otherwise mutually agreed upon. FCHP's eligibility guidelines are outlined in the *Administrative Handbook*. Employees must live or work within the service area applicable to the product in which they are enrolling.

Enrollment opportunity. That any enrollment opportunity is the same for the Plan as for any other health benefits program offered by the Employer.

Anniversary date. That the anniversary date, which is the annual date by which employees may choose to change to another health insurance option, shall be the same for the Plan as for any other health benefits program offered by the Employer.

Employer contributions. That the Employer shall contribute at least 50% of the Plan premium for individual coverage, and at least 33% of the premium for family coverage. In addition, the Employer must contribute the same amount toward the cost of the Plan membership as it does toward the cost of other health benefits options offered to its employees, not to exceed the Plan's premium. Except as hereafter provided, the group contribution set forth in the premium rate schedule shall not be changed during the term of the Agreement unless such change is agreed to in writing by the Plan. If, however, the Employer's contribution to such other coverage as may be available through the Employer is increased during the term of the Agreement, then the Employer agrees to increase its contribution to the Plan's coverage by an equivalent amount, effective the first Premium Due Date following such an increase.

Nondiscriminatory offer/equal contribution. That the Employer will comply with Massachusetts General Laws, Chapter 176G Section 6A, as clarified by Massachusetts Division of Insurance Bulletin 2007-04. M.G.L. Chapter 176G Section 6A prohibits the sale of fully insured coverage to an employer who offers coverage to its employees in a manner that 1) has the general effect of making coverage options available to higher-paid full-time employees that are not available to lower-paid full-time employees, and/or 2) has the general effect of providing a higher contribution level to higher-paid full-time employees than to lower-paid full-time employees.

Distribution of materials. That the Employer shall receive benefits materials from the Plan and make them available to each eligible employee prior to any enrollment period.

Annual enrollment period. That the Employer shall provide to its employees an annual re-enrollment period of sufficient length and conducted in a manner so as to meet the requirements for federally qualified health maintenance organizations. During this time eligible employees may transfer their membership from any existing health benefits program to the Plan or from the Plan to any existing health benefits program offered by the Employer.

Changes in benefits. That the Plan shall notify the Employer at least 60 days prior to any changes in benefits affecting the coverage for its employees unless mandated by law for less than a 60-day implementation. The Employer will notify its employees of any benefits changes.

Submission of reports. That monthly remittances, remittance reports, membership applications, change notices and any other transactions required to properly administer the Plan shall be submitted in accordance with the timetable and procedures established by the Plan (generally a period of 30 days from a qualifying event).

Premium payments. That the Employer shall remit to the Plan when due all premium amounts for its employees covered by the Plan, whether or not Plan services were rendered to these employees. The Plan has the right to cancel this Agreement and coverage to the Employer and its employees for non-payment of such premium amounts in accordance with the Plan's administrative guidelines. Any outstanding balances remaining due after the Plan is no longer offered to the Employer remain a liability of the Employer to the Plan. If the Employer has a broker of record, the broker may be eligible to receive a commission and/or bonus based on the amount of premium paid; the Plan will make specific commission information available on request. Employer agrees that the Plan may disclose to its broker of record member information for the purpose of assisting the Employer with its enrollment and/or disenrollment activities.

Entire agreement. That the contract between the Plan and the Employer shall include the provisions set forth in this Agreement; the premium rates charged by the Plan for the

benefits in effect for the Employer; the Plan's underwriting guidelines; the Plan's *Evidence of Coverage* for the benefits in effect for the Employer; the *Administrative Handbook*; any membership transaction forms submitted to the Plan by the Employer on behalf of its employees; and any additional contractual arrangements or amendments to the above (together, the "Contract"). The Employer agrees that the *Evidence of Coverage* and *Administrative Handbook* were received at the time of signing this Agreement. The Plan reserves the right to amend its underwriting guidelines, its *Evidence of Coverage*, its *Administrative Handbook* and its benefit interpretations without prior notice to the Employer.

Amendment. That this Agreement may be amended by agreement of the President or duly designated officer of the Plan, and the Employer, and that any amendments shall become part of this Agreement. Notwithstanding the foregoing, no agent of the Plan has the authority to change this Agreement, waive any of its provisions or restrictions or extend the time for making payment.

Effect of execution. That, upon execution of this Agreement, all previous Group Service Agreements between the Plan and the Employer relating to the offering of an FCHP HMO and any amendments thereto shall become null and void.

Employee requirements. That all employees enrolled by the Employer into the Plan are 1) full-time employees working 30 hours or more per week (including any owners of the business) or part-time employees working at least 20 hours per week and 2) receiving an employer contribution (of at least 50% of the premium for individual coverage, and at least 33% of the premium for family coverage) toward the health insurance coverage.

Plan access to records. That the Employer agrees to allow the Plan reasonable access to its payroll or other records so that the Plan may audit and verify any enrollee's eligibility for Plan coverage. Failure to comply with this provision may result in the Plan's termination of this Agreement as of a date it determines to be appropriate.

Fraud/misrepresentation. That if the Plan determines that fraud or misrepresentation has occurred on any of the forms, remittances, membership applications or any other transactions submitted by the Employer to the Plan, the Plan may terminate this Agreement retroactive to the date of the fraud or misrepresentation or as of the most recent group anniversary date or as of the next group anniversary date, at its sole discretion. The Employer will be responsible for reimbursing the Plan for the difference between any premium paid by the Employer and any medical care costs paid by the Plan from the point of the fraud or misrepresentation to the termination date.

Workers' compensation. That the Employer, if eligible to carry a Workers' Compensation policy, will maintain such a policy in effect with this Group Service Agreement. The Plan may terminate this Agreement as of the earlier of the date the Workers' Compensation policy is terminated or the Employer's most recent group anniversary, at its discretion.

Termination. That the Plan reserves the right to terminate this Agreement if premium payments are not received on time or within any applicable grace period; upon written notice, if there is no longer any covered enrollee who lives or works in FCHP's service area; if group membership is offered through an association and the employer's membership ceases; if FCHP ceases to offer coverage in the market, provided that all applicable notice and other provisions shall be complied with; or in the event of a material breach of the Agreement (with right to cure prior to the effectiveness of the termination).

That the Employer reserves the right to terminate the Agreement in the event of insolvency or bankruptcy of the Plan; in the event of the revocation of the Plan's licensure; or, in the event of a material breach of the Agreement (with right to cure prior to effectiveness of the termination). Should it be necessary for the Employer to terminate the contract due to extenuating circumstances outside the above, the Employer shall make every effort to give at least 30 days written notice to the Plan.

Applicable law. That the Agreement shall be governed by the laws of the Commonwealth of Massachusetts, as applicable. That both parties are required to comply with and maintain security measures outlined in Code of Massachusetts Regulations, 201 CMR 17.00, to protect personal information as defined therein. That both parties will comply with all applicable state and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Advertising policy. That the Employer shall not use the name or likeness of the Plan in any document or in any communication for any purpose, including, without limitation, advertising, promotional events, employee information collection or identification, or similar uses without the expressed written consent of the Plan. This includes, but is not limited to, newsprint or other printed media, television, radio, computer or other electronic communication methods.

Effective date. That this Agreement between the Plan and the Employer shall become effective as of the date shown on the front of this form and shall be effective to the Employer's next anniversary date and from year to year thereafter, unless terminated by either party by written notice. Each party will make every effort to give at least 60 days notice prior to the anniversary date.