

Administrative guide



Employee enrollment, payment procedures, and legal requirements

Issued and effective December, 2010



nhp.org



**Neighborhood
Health Plan™**

Your health. Our promise.



Neighborhood Health Plan™

Your health. Our promise.

Thank you for choosing NHP to provide health benefits to your employees.

NHP was founded in 1986 as a not-for profit managed care organization licensed by the Massachusetts Division of Insurance. We achieved NCQA accreditation for our commercial program in 2009, and remain committed to providing the highest levels of quality and customer service to you and your employees.

This *Administrative Guide* contains important information about enrolling your employees with NHP and accessing plan services.

If your employees have questions or need help with their NHP health benefits or coverage, they may call the NHP Customer Care Center at:

Phone **800-462-5449**
TTY 800-655-1761
Hours Monday–Friday, 8 a.m.–6 p.m.,
 Thursday, 8 a.m.–8 p.m.

Again, thank you for your business. We look forward to serving you.

Bernadette Di Re
Senior Director of Sales and Membership

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Section 1

Overview

Thank you for selecting Neighborhood Health Plan, Inc. (NHP) for your employees' health benefits. This *Administrative Guide* will answer common questions and help you complete membership transactions, including instructions on enrollment procedures and premium payments.

Massachusetts health-care reform

An employer requirement under the Massachusetts Health Care Reform Law is the requirement that employers with 11 or more full-time equivalent employees adopt and maintain a plan that satisfies both:

- Section 125 of the Internal Revenue Code
- Regulations established by the Commonwealth Connector (the Health Connector). This requirement went into effect on July 1, 2007.

What Is a Section 125 Plan?

Under federal tax law, a Section 125 Plan is a written plan that permits employees to choose between receiving cash (the employee's normal cash wages) and certain qualified benefits that can be paid for on a pre-tax basis by employees.

A Section 125 Plan may be established by any of the following:

- C corporations
- Partnerships
- S corporations
- Limited liability corporations
- Sole proprietorships
- Professional corporations

- Non-profit organizations

IRS regulations state that self-employed individuals are not employees. Therefore, self-employed individuals may establish but may not participate in a Section 125 Plan, although spouses or other family members who are employees may participate in some cases. A Section 125 "premium-only plan" allows an employee to pay their health-care coverage premiums on a pre-tax basis, thus lowering their taxable income and, consequently, their tax liability. An employee's election to pay for benefits on a pre-tax basis is made by entering into a salary reduction agreement with the employer. Under a salary reduction agreement, an employee elects to reduce his/her compensation by a stated amount on a pre-tax basis and those amounts are considered by the IRS to be employer contributions.

In effect, it is as if the employee has given up the right to receive that part of his/her salary before actually becoming entitled to it. Therefore, the employee's salary reduction contributions are not actually received by the employee, and thus, are neither considered wages for state and federal income tax purposes nor subject to FICA withholding. It is important to note that, under a Section 125 Plan, health-care coverage premiums may be paid entirely by employee salary reduction—employer contributions are not required.

For more information on Massachusetts health care reform, please visit the Commonwealth Connector website at www.mahealthconnector.org.

- For employees who have declined to participate in the employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement, please direct them to the *Employee Health Insurance Responsibility Disclosure Form* (found at www.nhp.org).

Important notice to employers, brokers, and third-party administrators

In order for NHP to administer the plan effectively, it is important that employer groups, brokers, and third party administrators notify NHP of enrollments, changes in membership status, and terminations in a timely and accurate manner.

Enrolling employees prior to the effective date of their coverage allows NHP to send identification (ID) cards and other membership materials that inform members about their health benefits prior to their use of health services. Enrollments and changes received by NHP more than 60 days after the effective date of coverage will be rejected by NHP, unless there is a qualifying event (see “Qualifying Events,” p.10).

NHP requires immediate notification of employee and dependent terminations

Certain participating providers are paid monthly, based on current membership. Therefore, NHP will continue to make payments to providers until you notify NHP of the termination of a member’s coverage.

NHP will process terminations retroactively to no more than 60 days from the date of receipt of the termination. Employers are required to pay the applicable monthly premium due for coverage provided prior to the termination effective date. Timely communication from employer groups and third party administrators allows NHP to better manage membership information, delivery of care, and premium rates.

Employer materials

Upon the employer group’s enrollment with NHP, the designated benefits administrator will receive the following items:

- Group application form

- *Massachusetts Employer Group Health Benefits Agreement/Contract*
- *Member Handbook, Benefit Summary*, and any rider information
- Prescription drug coverage brochure
- Monthly premium invoices listing each employee and the corresponding premium
- Enrollment and marketing materials
- *Administrative Guide* (available as a hard copy and also online at www.nhp.org)
- Correspondence about administrative news or specific events

Subscriber materials

Upon receipt of complete and accurate enrollment information, NHP will send to the subscriber:

- An ID card for each covered individual
- *Member Handbook, Benefit Summary*, and any rider information
- Prescription drug coverage brochure
- Member newsletters—*Our Neighborhood*
- Benefit update notifications describing significant benefit changes, as mandated by law or as agreed upon by the employer group and NHP
- *Notice of Privacy Practices*

NHP departments

NHP’s administrative departments are available to help when a member has a question or needs a particular service. This section outlines the departments to contact for assistance.

QUESTIONS?

Call NHP’s Customer Care Center 800-462-5449 (TTY 800-655-1761) Mon.–Fri., 8 a.m.–6 p.m., Thurs. 8 a.m.–8 p.m. | www.nhp.org

Sales

The Sales Department has overall responsibility for the employer group. Contact your sales account executive when you need:

- Information about the group agreement or premium rates
- Information about NHP benefits plan
- NHP forms or brochures

Address Neighborhood Health Plan
Sales Department
253 Summer Street
Boston, MA 02210

Phone 800-433-5556
*Press 1 for English or 2 for Spanish,
then select option 4.*

Fax 617-772-5509

Customer Care Center

The Customer Care Center provides customer service for issues related to enrollment processing, premium invoicing, and eligibility. Contact the Customer Care Center with questions about:

- Completion of *Enrollment and Change Forms*
- Eligibility
- Premium invoices
- Online group administration services
- Benefits and coverage
- Eligibility
- Claims
- ID cards (new or replacement) and member materials
- Primary care physician (PCP) changes

The Customer Care Center has a policy on making changes to member accounts via telephone calls. The following changes can be made with a telephone call:

- Demographic changes, including address and telephone number
- PCP/site changes
- Minor name spelling corrections

The following changes *cannot* be made with a telephone call. These changes require the use of an *Enrollment and Change Form*:

- First or last name changes
- Newborn first names
- Dates of birth
- Gender
- Social Security number

Send changes to:

Address Neighborhood Health Plan
Customer Care Center
253 Summer Street
Boston, MA 02210

Phone 800-462-5449
TTY 800-665-1761

**Coordination of benefits/
third party liability (TPL)**

The TPL department coordinates with third parties to determine primary and secondary payment responsibilities when other insurance benefits exist and when a third party may be responsible for claims payment. Employers and members may contact NHP with questions or to submit information relating to third-party liability.

Address Neighborhood Health Plan
Coordination of Benefits/
Third Party Liability
253 Summer Street
Boston, MA 02210

Phone 800-462-5449
Fax 617-526-1985

Online information

NHP's website, www.nhp.org, contains a wide range of educational and interactive information about NHP's benefits, services, and health programs. It is organized into four sections:

- For Members
- For Providers
- For Employers & Brokers
- Need Health Insurance

Online options for members include:

- "Your Benefits" information page
- Member programs and discounts
- Healthwise Knowledgebase
- *Health Needs a Plan* book
- Provider directories

- *Benefit Summaries*
- Multilingual resources
- Online health risk assessment tool
- Guidelines for staying healthy
- Member newsletter, *Our Neighborhood*
- Smart Neighbor, NHP's community resource database
- Health insurance glossary
- Drug Lookup
- Frequently asked questions (FAQs) section

The most current version of this *Administrative Guide* is available at www.nhp.org. Within the "Employers/Brokers" section, you will also find other helpful tools and forms, as well as COBRA information.

Section 2 Eligibility and enrollment

There is no pre-existing condition limitation or exclusion under the plan with Neighborhood Health Plan (NHP.) NHP does not use the results of genetic testing in making any decisions about enrollment, renewal, payment, or coverage of health-care services, nor does NHP consider any history of domestic abuse or actual or suspected exposure to diethylstilbestrol (DES) in making such decisions.

NHP will accept members into our plan regardless of their income, physical or mental condition, age, gender, sexual orientation, religion, physical or mental disability, ethnicity or race, previous status as a member, pre-existing conditions, and/or expected health status. Upon notification of a member’s enrollment, NHP will mail the member a member ID card which indicates the member’s effective date of enrollment with NHP.

NHP is not responsible for any services a future member receives prior to their effective date of enrollment with NHP.

The NHP service area

An eligible employee may enroll in NHP if they are actively working for an employer who is based in the NHP service area, and if they are enrolling in NHP through the employer’s group plan.

NHP’s service area includes most communities in Massachusetts. (See list below.)

Subscriber eligibility

Eligible subscribers of NHP include:

- Individuals who have permanent residence in the NHP service area
- Employees of a sole proprietorship, firm, corporation, partnership, or association actively engaged in a business that is based within the NHP service area

Eligible employees may enroll in NHP through their employer group if they:

- Are actively employed by a qualified contributing or non-contributing Massachusetts employer, and
- Meet all employer eligibility requirements (i.e., probationary period)

Dependent eligibility

The following individuals are eligible for enrollment, as a dependent of the subscriber:

- A legally married spouse of a subscriber
- A divorced spouse of a subscriber is eligible to remain covered until they or the subscriber remarries or unless the divorce decree specifies otherwise, the date or event specified in the decree

NHP SERVICE AREA					
County	City/Town	County	City/Town	County	City/Town
<i>Barnstable</i>	Entire county	<i>Plymouth</i>	Abington, Bridgewater,	<i>Suffolk</i>	Entire county
<i>Bristol</i>	Entire county		Brockton,	<i>Worcester</i>	Entire county
<i>Dukes</i>	Entire county		East Bridgewater,		
<i>Essex</i>	Entire county		Hanover, Hingham, Hull,		
<i>Hampden</i>	Entire county		Marshfield, Mattapoisett,		
<i>Middlesex</i>	Entire county		Norwell, Rochester,		
<i>Norfolk</i>	Entire county		Rockland, Scituate,		
			West Bridgewater,		
			Whitman		

- A natural child of the subscriber or the subscriber’s spouse who is eligible for coverage is eligible for coverage as a dependent through the earlier of:
 - » The dependent’s 26th birthday, or
 - » For two years after the end of the calendar year in which such person last qualified as a dependent under 26 U.S.C. Section 106
- An adopted child of the subscriber or the subscriber’s spouse who is eligible for coverage is eligible for coverage as a dependent through the earlier of:
 - » The dependent’s 26th birthday, or
 - » For two years after the end of the calendar year in which such person last qualified as a dependent under 26 U.S.C. Section 106. The date of placement in the home for the purpose of adoption is the effective date of the child’s coverage or if the child has been residing in the home as a foster child for whom the beneficiary has received foster care payments, the effective date is the date of the filing of the petition to adopt.
- A person who is under legal guardianship with a subscriber is eligible for coverage is eligible for coverage as a dependent through the earlier of:
 - » The dependent’s 26th birthday, or
 - » For two years after the end of the calendar year in which such person last qualified as a dependent under 26 U.S.C. Section 106. Documentation must be provided that includes a court document signed by a judge indicating the child’s name, the appointed legal guardian(s), the temporary or permanent designation, the effective date and, if temporary legal guardianship, the termination date.
- A child of a dependent of the subscriber is eligible for coverage as a dependent through the earlier of:
 - » The child’s 26th birthday, or
 - » For two years after the end of the calendar year in which such person last qualified as a dependent under 26 U.S.C. Section 106. However, when the parent of such child is no longer a dependent of the subscriber, the child shall no longer be a dependent.
- Children who are recognized under a qualified medical child support order as having the right to enroll for coverage under the plan

Eligibility rules for dependent children

Eligibility for dependent coverage, including adoptive children and newborns, has been extended to age 26. IRS dependents include the dependents who are claimed on the subscriber’s or spouse’s federal tax return, are eligible for coverage up to age 26. Non-IRS dependents are eligible for coverage up to two years following loss of IRS dependent status.

The date on which a dependent loses dependent status is December 31 of the last federal tax year in which the person was claimed as a dependent on another person’s tax return. On an annual basis, NHP will validate the dependent’s eligibility.

The subscriber must complete the *Application for Coverage of Dependents Age 19–26*. If the subscriber does not complete the form and return it to NHP within 30 days of receipt of the form, the dependent’s coverage will end on the 30th day.

If a dependent age 19 or over is not a handicapped dependent, he/she is eligible for continued coverage under the Massachusetts Health Care Reform Act. IRS dependents are eligible for coverage up to age 26. Non-IRS dependents are eligible for coverage up to two years after losing IRS dependent status according to Internal Revenue Code rules, whichever occurs first. The insured must have family plan coverage.

The subscriber must notify NHP when a dependent ceases to be an IRS dependent or becomes disabled. At that time, the subscriber can apply for continued coverage by completing, in full, the *Application for Coverage of Dependents Age 19–26*.

QUESTIONS?

Physically or psychologically challenged dependents

A dependent child who is incapable of earning his/her own living due to a disability and who is enrolled under the subscriber's plan will continue to be covered after he/she would otherwise lose dependent eligibility, so long as the child continues to be incapable of earning his/her own living due to a disability. Dependents who, at age 19, are incapable of earning their own living due to a physical or psychological challenge may be eligible for Dependent with a Physical or Psychological Challenge Coverage.

Subscribers should contact NHP for the *Application for Physically or Psychologically Challenged Dependent Child* to apply for this coverage. The dependent's application will be reviewed and, if approved, the child's coverage will be continued on either a temporary or permanent basis.

Dependent Eligibility Change for NHP Commercial Insurance/ Patient Protection and Affordable Care Act

Under current Massachusetts law, dependents may stay on their parent's commercial health plan for up to two years after the loss of their IRS dependent status, up to age 26. Under the new national health care legislation (Patient Protection and Affordable Care Act), effective September 23, 2010, dependents may stay on their family's plan until age 26, without consideration of IRS status.

NHP is committed to ensuring continuity of coverage for our members. In the interim period, prior to the new legislation taking effect, NHP will allow dependents currently covered under their family's plan to remain on the plan until age 26, regardless of IRS status. Effective September 23, dependents under age 26 not currently enrolled in their family's plan may enroll in the plan during the normal renewal period. Please feel free to contact our Customer Care Center at 800-462-5449 if you have any questions or concerns.

Effective dates and enrollment requirements

Persons who meet the eligibility requirements may enroll in NHP by submitting a completed enrollment application. An applicant is enrolled only upon NHP's acceptance of the enrollment application. NHP's acceptance will be based upon timely receipt from the group of the enrollment application and the applicable premium and satisfaction of all the requirements of the *Group Health Benefits Agreement*, including the *Subscriber Agreement*, as amended from time to time.

Open enrollment

- An initial NHP open enrollment period shall take place prior to the effective date of the group agreement or other date agreed upon by NHP and the group.
- An annual open enrollment period shall be held prior to the group's contract anniversary date or other date agreed to by NHP and the group.
- During an enrollment period, the group shall distribute information about NHP, including a listing of NHP primary providers. The group will review with NHP any communication regarding NHP prior to its distribution to employees.

Time and procedure for enrollment

- Eligible employees may select NHP coverage during the initial enrollment or the group's annual open enrollment. Newly hired employees may become subscribers when eligible under the group's benefits eligibility policies. All other applications of membership and changes in status or type of coverage will be accomplished according to the subscriber agreement.
- NHP must receive written notice (on a form supplied or approved by NHP) of the enrollment of members or changes between individual and family coverage no more than 60 days after any such change is to be effective. If timely notice of enrollment is not given because of administrative error, NHP may, at its option, allow enrollment of the member upon explanation of the

circumstances by the group. Otherwise, if timely notice of enrollment is not given, the effective date of coverage shall be no more than 60 days prior to NHP’s receipt of notification of enrollment.

Member status changes

It is a member’s responsibility to notify their employer about any changes that may affect them or their dependents’ eligibility for coverage, such as:

- An addition to the family
- The marriage of a dependent
- An address change
- Death of a member
- Change in marital status

See “Retroactivity guidelines.”

NHP must have a member’s current address and telephone number on file so that we can contact them when necessary, and correctly process claims for care outside the NHP service area. Members should contact their employers to make any changes or corrections to their address and telephone number.

Eligible employees of a qualified Massachusetts employer group may enroll in NHP within 30 days of losing other coverage if:

- The employee’s spouse or eligible dependent has lost other insurance*
- The employee marries
- The employee has a newborn or adopts a child†
- The employer’s contributions toward the dependent’s coverage are terminated*

*The effective date must be no later than the first day of the first month after NHP receives the enrollment request.

†The effective date must be the date of birth in the case of a newborn dependent, or, in the case of an adoptive dependent, the effective date must be the date of adoption or placement for adoption.

NHP member card

NHP will mail members a permanent NHP member identification (ID) card within seven calendar days of enrollment. The NHP member ID card has important information about members and their benefits. It also tells providers and pharmacists that the person is a member of NHP and how much their copayment for services should be. (See ID card example below.)

Each NHP member is issued an NHP member ID card with the following information:



1 Member name
2 NHP identification number

3 Prescription drug coverage identifier (when applicable)
4 Group or employer category

5 Date of birth
6 Copayment amounts (when applicable)

QUESTIONS?

Members should show the NHP member ID card whenever they get health care or fill a prescription. Members should always carry their member ID card with them so it will be handy when they need care.

Members should read their cards carefully to make sure all the information is correct. If a member has questions or concerns about their NHP member ID card, or if they lose it, they should call our Customer Care Center. Members should not let anyone else use their NHP member ID card for any purpose, including obtaining health-care services.

NHP member rights and responsibilities

Rights as an NHP member

As a valued member of NHP, members have the right to:

- Receive information about NHP, our services, our providers and practitioners, a member's covered benefits, and their rights and responsibilities as a member of NHP.
- Receive oral interpretation services free of charge for any materials in any language.
- Have their questions and concerns answered completely and courteously.
- Be treated with respect and with consideration for their dignity.
- Have privacy during treatment and expect confidentiality of all records and communications.
- Discuss and receive information regarding their treatment options, regardless of cost or benefit coverage, with their provider in a way which is understood by the member.
- Be included in all decisions about their health care, including the right to refuse treatment.
- Change their primary care provider.

- Access emergency care 24 hours a day, seven days a week.
- Access an easy process to voice their concerns, and expect follow-up by NHP.
- File an appeal (grievance) or complaint if they have had an unsatisfactory experience with NHP or with any of our contracted providers or if they disagree with certain decisions made by NHP.
- Make recommendations regarding NHP's member rights and responsibilities.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Freely apply their rights without negatively affecting the way NHP and/or their provider treats them.
- Ask for and receive a copy of their medical record and request that it be changed or corrected.
- Receive the covered health-care services they are eligible for as outlined in the *Member Handbook*.
- Make decisions about their medical care, including the right to accept or refuse medical or surgical treatment.
- Receive a second opinion on a medical procedure and have NHP pay for that service.
- Create and apply and Advance Directive, such as a will or a health care proxy, if they are 18 years of age or older.

Responsibilities as an NHP member

As a member of NHP, members also have responsibilities. It is a member's responsibility to:

- Choose a primary care provider, the provider responsible for a member's care.

- Call their primary care provider when they need health care.
- Tell any health-care provider that they are an NHP member.
- Give complete and accurate health information that NHP or their provider needs in order to provide care.
- Understand the role of primary care provider in providing them care and arranging other medical services that they may need.
- Understand their health problems and take part in making decisions about their health care and in developing treatment goals with their provider.
- Follow the plans and instructions agreed to with their provider.
- Understand their benefits—what’s covered and what’s not covered.
- Call their primary care provider within 48 hours of any emergency or out-of-area treatment. If they experienced a behavioral health (mental health and substance abuse) emergency they should contact their behavioral health provider, if they have one.
- Notify NHP and their employer of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, etc.

How to enroll employees and dependents

Enrollment and Change Form

The *Enrollment and Change Form* collects necessary member information that is used for accurate member enrollment. The *Enrollment and Change Form* must be filled out completely and legibly. When an employee completes the form, it should be returned directly to the employer’s benefits officer.

Notification of enrollment requests must be received within 60 days of the effective date of coverage. If NHP does not receive notification of enrollment within 60 days, the employee and/or dependent(s) cannot be enrolled until the next open enrollment period or until a subsequent qualifying event.

- NHP processes *Enrollment and Change Forms* in the order in which they are received. Employers should submit *Enrollment and Change Forms* as early as possible to ensure accurate and timely enrollment of employees.
- Incomplete forms will delay enrollment processing and the issuance of ID cards and may result in a denial of enrollment.
- If NHP does not receive the form prior to the effective date, services may be denied.

Qualifying events

The following are examples of when an eligible employee may be added to the group plan:

- **Open enrollment** (commercial group renewal/anniversary date)
- **Date of hire**
- **After any applicable probationary period imposed on new employees**—Employers must have a consistent probationary period in place for new hires (e.g., 30 days after date of hire, or first of next month after date of hire, etc.). The date of hire and requested effective date must be listed on the application.
- **Increase in hours worked**
- **A qualifying event where an employee begins working the necessary hours to qualify for group health insurance through an employer**
- **Involuntary loss of prior group health insurance**—Documentation from the prior employer and the prior health insurance plan indicating the termination date of coverage

QUESTIONS?

Call NHP’s Customer Care Center 800-462-5449 (TTY 800-655-1761) Mon.–Fri., 8 a.m.–6 p.m., Thurs. 8 a.m.–8 p.m. | www.nhp.org

and the termination reason must be provided with the completed enrollment form.

- **The occurrence of a life event**—Life events include marriage, birth of a child, adoption of a child, legal guardianship of a child

Changes of existing individual memberships to family coverage may occur upon the following events as long as the request is received within the retroactivity guidelines:

- **Open enrollment**
- **Marriage**—The effective date must be the date of marriage.
- **Birth of a child**—A completed enrollment and change form is required. The effective date must be the child's date of birth.
- **Adoption of a child**—Documentation from the adoption agency indicating the date of placement of the child in the home for the purpose of adoption along with a completed *Enrollment and Change Form*. The effective date must be the date of placement of the child.
- **Legal guardianship of a child**—Court documents signed by a judge along with a completed *Enrollment and Change Form*. The effective date must be the date legal guardianship is granted.
 - » Legal guardianship can be granted on either a temporary or permanent basis. If the legal guardianship is granted on a temporary basis, the child is eligible for coverage for only the length of the legal guardianship.
- **Involuntary loss of spouse's or child's prior group health insurance**—Documentation from the spouse's or child's group indicating termination reason and termination date along with a completed *Enrollment and Change Form* is required. The effective date must be the termination date of the prior coverage.

Primary Care Physician (PCP) selection requirements

Please be aware that all members are required to choose a PCP upon enrollment. The PCP is responsible for providing or arranging most of the member's medical care. Therefore, if a PCP is not selected, certain services may not be covered, or may be subject to additional member out-of-pocket expenses.

How to complete an Enrollment and Change Form

Enrollment and Change Forms are available online at www.nhp.org. In order to ensure that your employees are enrolled quickly and correctly, all applicable fields of the *Enrollment and Change Form* must be completed.

The completed form must be signed and dated by the employee and the employer. The important fields to be completed are:

- Reason for enrollment or change
- NHP group number (This is a three- or four-digit number exclusive to the group.)
- Employer name
- Date of employment
- Requested effective date of coverage
- Last name
- First name
- Middle initial
- Male or female
- Date of birth
- Employee Social Security number
 - » Federal law requires group health plans to collect Social Security numbers (SSN) of members. This law was created to enable reporting to Medicare.* In order to comply with this law, NHP requests SSNs for all members; as part of the enrollment process,

the SSN is required for new employees or dependents when they enroll. Providing SSNs is not voluntary. If you do not provide SSNs for employees, you may face substantial penalties for non-compliance. The SSN is used only to comply with Medicare reporting regulations. To find out more about this law, visit www.cms.hhs.gov/mandatoryinsrep, which includes an official “ALERT” document from the Office of Medicare & Medicaid Services which you can provide to employees.

*Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), adds new mandatory reporting requirements for GHP arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers’ compensation. See 42 U.S.C. 1395y(b)(7) & (8).

- Home phone
- Work phone
- Complete mailing address
- Complete spouse and child information, if applicable
- Primary language spoken
- Other insurance information, if any
- Type of NHP coverage requested (depending on availability): self; individual/spouse; individual/child(ren); family
- Primary care site selected (auto-assignment will be used if this field is left blank)
- Primary care physician selected (auto-assignment will be used if this field is left blank)
- Medicare information, if any

After reviewing each employee’s application for completion, employers should:

- Send the top copy of the application to NHP’s Enrollment Department.
- Retain the middle yellow copy for your files.
- Give the bottom pink copy to the employee for their records.

Completed *Enrollment and Change Forms* must be sent to NHP. (For faster processing, faxing is the best option.)

<i>Address</i>	Neighborhood Health Plan, Inc. 253 Summer Street Boston, MA 02210
<i>Fax</i>	617-526-1981

Whenever possible, NHP should receive the *Enrollment and Change Form* before the member’s effective date of coverage. However, when a member needs urgent care in the next 24–48 hours, and NHP has not yet received notification of the enrollment, you may call our Customer Care Center.

Assignment of NHP member ID numbers

Identification numbers are assigned using a system-generated seven-digit number immediately preceded by the letters NHP. The ID numbers will look as follows:

- NHP1234567
-

QUESTIONS?

Section 3

Renewal/ termination of coverage

The Agreement shall be effective from “begin date” until “end date” (the “first anniversary date”), and shall be renewed automatically for 12-month increments on each subsequent anniversary of the first anniversary date, subject to amendments, unless terminated in accordance with the termination provisions set forth below. Each of the first anniversary date and the subsequent anniversary of such date is referred to as a “contract anniversary date.”

Termination of member coverage

Neighborhood Health Plan (NHP) requires notification from the employer group to terminate a subscriber’s contract. Notice is required in the following cases:

- When an employee terminates employment
- When an employee has a reduction in hours that results in a loss of eligibility for coverage
- When an employee elects to voluntarily terminate membership, switches to another plan at open enrollment, or otherwise terminates his/her entire membership with NHP.

By the group or the subscriber

NHP must receive written notice on a form supplied or approved by NHP of the termination of members no more than 60 days after any such change is to be effective.

If timely notice of termination is not given, the retroactive effect of such termination shall be limited to a date 60 days prior to the receipt by NHP of written notice of termination.

Coverage ends at midnight on the date a member’s coverage is terminated. There is no coverage for any services received after midnight

on the date a member’s coverage terminates. All authorizations for services issued by NHP or participating providers assume confirmation of membership and are invalid after termination of membership, including retroactive terminations.

By NHP

NHP may terminate the individual rights of members under the conditions specified in the subscriber agreement. All of the terminated member’s rights to benefits shall cease as of the effective date of the member’s termination by NHP.

Termination of group agreement

Voluntary termination

Except as set forth below, either NHP or the group may terminate this agreement by giving written notice to the other at least 30 days before the next contract anniversary date to be effective on such contract anniversary date.

- **Termination for failure to pay premiums**—In NHP’s discretion, if the group has not paid all premiums due by the due date as described above, NHP may terminate the group agreement immediately upon prompt written notice to the group. The termination shall become effective in accordance with the written notice. All rights to health-care benefits under the group agreement and the subscriber agreement shall terminate on the effective date set forth in such notice.
- **Cessation of operation**—If NHP ceases operation or becomes unable to provide benefits set forth in the group agreement, then NHP may terminate the group agreement upon giving the group at least 90 days’ written notice. The termination shall become effective in accordance with the written notice. All rights to health care benefits under this agreement and the

subscriber agreement shall terminate on the effective date set forth in such notice.

- For more information, visit the state of Massachusetts website at www.mass.gov. (Type “940 CMR 9.00” in the search bar.)

Using the *Enrollment and Change Form*

This form may be used to terminate the subscriber’s entire contract. Please provide the following information:

- Reason for submission, and check “Termination and Reason for Change in Enrollment.”
- Your employer name and number
- The subscriber’s ID number (NHP contract or Social Security number)
- The employee’s full name and address
- The termination date in the “Termination Effective Date” box*
- Employer signature and date. The employee’s signature is not required on a subscriber termination

Do not mark up the monthly invoice or send in terminations with the premium payment. This could delay the processing of the terminations and the reflection of termination credits on the invoice. If reporting terminations for individual member(s) other than a subscriber, refer to the section “Member status changes.” Consistent with HIPAA Privacy Rule provisions, if terminations and enrollments are reported via email, information must be contained within a password-protected file prior to transmission.

**Enrollment and Change Forms* submitted to NHP with termination effective dates on the first of the month will be changed to the last day of the previous coverage month when processed. For example, if the *Enrollment and Change Form* is received with an effective date of June 1, NHP will process the transaction effective May 31. Coverage will be effective until midnight on May 31.

Retroactivity guidelines

Transactions such as additions, changes to family, adding a dependent, and terminations are allowed within 60 days of the requested effective date.

Exceptions to this policy are considered on a case-by-case basis and require documentation from the employer explaining why the request for the exception is being made.

- Some accounts have different retroactivity guidelines.

The group invoice

Rates

Unless otherwise agreed to in writing, or when required as a result of a change in applicable law, changes in rates from year to year under the group agreement will take effect on each contract anniversary date. Except when rates are changed due to changes in applicable law, NHP shall give written notice to the group of rate changes at least 30 days prior to the next contract anniversary date.

Billing

Billing will be made on a monthly billing cycle for coverage beginning on the first of each monthly billing cycle. Bills will be mailed approximately 10 days before the first day of each monthly billing cycle and shall be due and payable no later than the first day of the monthly billing cycle for which the premium is applicable (i.e., billing is generated in January for February coverage).

- NHP will determine daily pro-rata amounts for additions to and terminations of enrollments.

Payments

The group shall submit to NHP the appropriate amount when due for each subscriber and enrolled dependent. The group shall act as the subscriber’s agent in this respect and shall not be NHP’s agent for any purpose.

QUESTIONS?

Call NHP’s Customer Care Center 800-462-5449 (TTY 800-655-1761) Mon.–Fri., 8 a.m.–6 p.m., Thurs. 8 a.m.–8 p.m. | www.nhp.org

- Only members for whom the agreed-upon premium payment is actually received by NHP are covered hereunder and only for the period for which the premium payment applies.
- If NHP has not received the appropriate premium payment from the group by the monthly due date, NHP may, in its discretion, terminate the group agreement effective as of the last date for which premium was received. As of the effective date of termination, the rights of members under the group agreement, including the subscriber agreement, shall cease. Coverage may be reinstated only through renewed application and re-enrollment in accordance with all requirements of the group agreement. NHP shall not be responsible if the group fails to pay NHP at all, or fails to pay NHP on a timely basis, even if the group has already charged the subscriber (for example, by withholding employee contributions) for part or all of the premium payment.
 - » For other requirements, see “Termination of group agreement,” p. 13.
- Without waiving any of its rights listed, NHP may accept late payment provided the group pays a late payment charge of 1.5% per month on any balance that is over 30 days overdue.
- The group shall inform NHP of the amount of its contribution toward each health maintenance organization (each, an “HMO”) and indemnity plan offered by the group and the contribution percentage of the premiums due hereunder at least 30 days before the contract anniversary date each year. Such contribution shall not be changed except upon 30 days’ notice to NHP and shall be effective only on the group’s next contract anniversary date. The contribution that the group makes toward the cost of NHP premiums shall be an amount that does not financially discriminate against an employee who enrolls in an HMO. NHP

shall have the right to review the group’s method of determining its contribution toward premiums. The group’s contribution toward the cost of HMO premiums shall not be deemed to be discriminatory if the group’s method of determining contributions on behalf of all employees is reasonable and is designed to assure employees of their choice among health benefit plans.*

*For more information on state laws governing such payments, go to www.mass.gov and type “Sec. 211 CMR 66” into the search bar.

Adjustments

NHP shall refund prepayments made on behalf of members whose coverage is subsequently terminated, provided that the group notifies NHP within 60 days after the effective date of termination, and provided that NHP has not paid claims on behalf of the subscriber or his/her eligible dependents. If claims have been paid on behalf of the subscriber or his/her dependents, then the effective date of termination will be the first day after the last claim was paid.

Member copayments

Members shall pay copayments for certain covered services as described in the subscriber agreement, or evidence of coverage. Deductibles, coinsurance, and out-of-pocket maximums may also apply.

- **Copayment**—A fixed amount paid by a member for applicable services or for prescription medications at the time they are provided.
- **Deductibles**—The amount a member must pay each year for certain services before they are covered. Amounts vary by plan, and by individual and family coverage.
- **Coinsurance**—A percentage of covered charges that must be paid by members for certain services. Coinsurance amounts vary by plan. Usually applies after the deductible is reached.

- **Out-of-Pocket Maximum (OOP)**—Maximum amount member would pay each year for certain services. After OOP is reached, services are covered in full for remainder of year. Amounts vary by plan, and by individual and family coverage. Deductibles, coinsurance, and copayments may apply to OOP.
- The details for each group lists each subscriber covered under the plan and indicates family or individual coverage.
- The amount due or credited for each member is listed and this amount reflects adjustments for any enrollment transactions processed within the month indicated.

The invoice

The invoice details the previous balance, the due date, and the subtotals for each group within the account (i.e., you may have a main group and a COBRA group).

- The grand total is then indicated. The summary page is to be returned with your payment.

If you have any questions about the group invoice, contact your sales representative.

Premium payments


Send payments to:

Address Neighborhood Health Plan
P. O. Box 844057
Boston, MA 02284-4057

Invoice Example

ACCOUNT BILLING AND PREMIUM INFORMATION

Indicates coverage period for this invoice.



YOUR COMPANY NAME
YOUR ATTENTION TO
YOUR ADDRESS
YOUR CITY, STATE ZIP CODE

Breakdown of individual subscriber information including member name and product type coverage.

Date by which premium must be paid.

Page: 0

PREMIUM ACTIVITY STATEMENT

DATE 05/15/2008
DUE DATE 05/01/2008

Group Number	ARAC100000123
Balance Due	\$2,607.78

Inquiries Billing: (617) 478-7170
Email: Billing@nhp.org
Enrollment: 1-800-462-5449

Mail Payments to:
Neighborhood Health Plan
P.O. Box 844057
Boston, MA 02284-4057

Processing Date
Membership transactions and premium payments received too late to be processed for the current billing period will be reflected in the next month's billing period with charges or credits.

THIS STATEMENT INCLUDES A PAST DUE BALANCE - PLEASE REMIT PAST DUE BALANCE IMMEDIATELY

Detach along this line and return with payment due

Group Name	YOUR COMPANY NAME	Current Coverage Period	05/01/2008 through 05/31/2008	DATE	05/15/2008		
Group Number	ARAC100000123	Transactions Processed Through 04/18/2008					
Neighborhood Health Plan Roster							
ID No.	Subscriber Name	Product / Coverage Type	Type	Date	Contract Rate	Coverage Period	Total Charges
XXXXXXXX0123	DOE, JANE	NHP_CARE / Individual			325.97	0.00 ^F 325.97 ^F	325.97
XXXXXXXX2345	DOE, JOHN	NHP_CARE / Individual			325.97	0.00 ^F 325.97 ^F	325.97
XXXXXXXX345A	SMITH, JANE	NHP_CARE / Individual and Spouse			651.95	0.00 ^F 651.95 ^F	651.95
XXXXXXXX456A	SMITH, JOHN	NHP_CARE / Individual			325.97	0.00 ^F 325.97 ^F	325.97
XXXXXXXX567A	BROWN, JOHN	NHP_CARE / Individual			325.97	0.00 ^F 325.97 ^F	325.97
XXXXXXXX678A	BLANK, WILL	NHP_CARE / Individual and Spouse			651.95	0.00 ^F 651.95 ^F	651.95

Current Coverage Contract Summary

Product	#Contracts / ContractType	Contract Rate	Total
NHP_CARE	4 Individual	325.97 ^F	1,303.88
NHP_CARE	2 Individual and Spouse	651.95 ^F	1,303.90
Total Contracts	6 Contracts	Total Current Charges^F	2,607.78

Contract Summary Summary of the number of contracts and product types included in this bill.

Total New Charges 0.00^F 2,607.78^F 2,607.78

Add Previous Balance \$1,955.84^F

Deduct Payment 03/27/2008 \$1,955.84^F

Adjustment 0

BALANCE DUE - 05/01/2008 **\$2,607.78**

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

Deduct Payment payment received since last invoice.

Adjustment any adjustments made to your account since the last billing.

QUESTIONS?

Section 4

Continuation coverage

COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Most employers with 20 or more employees are subject to COBRA and must offer employees and their eligible dependents the option to continue group health insurance coverage at the employee's expense for specific lengths of time. COBRA continuation coverage can become available to an employee when he/she would otherwise lose their group health coverage. It can also become available to other members of the subscriber's family who are covered under the plan when they would otherwise lose their group health coverage.

The federal government does not recognize domestic partners or same-sex spouses as eligible dependents. Therefore they are not considered eligible COBRA beneficiaries. For employer groups that provide coverage for domestic partners or same-sex spouses, Neighborhood Health Plan (NHP) will approve requests from employer groups to offer COBRA continuation coverage to domestic partners and same-sex spouses. However, employers who exercise this option should consult their tax counsel to understand the tax implications of this choice.

For additional information about employee rights and obligations under the plan and under federal law, employees should review the plan's *Summary Plan Description* or contact the plan administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation

coverage must be offered to each person who is a "qualified beneficiary." The employee, his/her spouse, and dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

An employee will become a qualified beneficiary if he/she loses coverage under the plan because one of the following qualifying events happens:

- Hours of employment are reduced, or
- Employment ends for any reason other than his/her gross misconduct.

For the spouse of an employee, he/she will become a qualified beneficiary if he/she loses coverage under the plan because any of the following qualifying events happens:

- The employee dies.
- The employee's hours of employment are reduced.
- The employee's employment ends for any reason other than his/her gross misconduct.
- The employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
- The spouse becomes divorced or legally separated from the employee.

Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his/her gross misconduct.

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA coverage available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan administrator of the qualifying event.

Members must give notice of some qualifying events

For the other qualifying events (divorce, legal separation of the employee and spouse, or a dependent child’s losing eligibility for coverage as a dependent child), members must notify the plan administrator within 60 days after the qualifying event occurs.

How is COBRA coverage provided?

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage (for qualified beneficiaries) lasts for up to

a total of 36 months when the qualifying event is one of the following:

- The death of the employee
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both)
- The employee’s divorce or legal separation
- A dependent child’s losing eligibility as a dependent child

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage**—If the employee or anyone in his/her family covered under the plan is determined by the Social Security Administration to be disabled and he/she notifies the plan administrator in a timely fashion, the employee and his/her entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before

QUESTIONS?

the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The employee must include a copy of the letter from the Social Security Administration notifying him/her or his/her family member of Social Security eligibility.

- **Second qualifying event extension of 18-month period of continuation coverage**—If the employee’s family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.
- In the event of a covered employee’s reduction of hours or termination, the employer must notify the eligible individuals of their COBRA rights at the time of the qualifying event.
- In the event of a dependent reaching maximum age, a divorce or a legal separation, the employee must notify the employer within 60 days of the event. The employer then has 14 days to notify the subscriber and dependent(s) of their COBRA rights.
- In the event of the covered employee’s death or Medicare entitlement or the employer’s bankruptcy, the employer has 14 days from the notice of such event to notify the eligible individuals of their COBRA rights.
- Upon receipt of the notice of COBRA rights, eligible individuals have 60 days to elect COBRA. Each eligible member has an independent right to elect COBRA coverage.
 - » Employers who use a TPA have an additional 30 days to notify their plan administrator.

NHP requests the following:

- As soon as possible after the qualifying event occurs (but within 60 days), submit a termination request via an *Enrollment and Change Form* to remove the employee, spouse, and/or dependent(s) from the group coverage. This step will relieve the employee of his/her responsibility for those premium payments during the member’s election period.
- When the eligible individual(s) elects the continuation coverage submit an enrollment request via an *Enrollment and Change Form* is used. The form must indicate the effective date of COBRA and the Reason for Submission as “COBRA Reinstatement.”

Employer election notification responsibilities

Notifying employees, spouses and dependents of their rights under COBRA and notifying NHP when persons elect to continue coverage is the employer’s responsibility. The following are COBRA notification requirements:

- Employers are required to provide a notice of COBRA rights to covered employees and spouses upon enrollment in a group health plan.

Employer responsibility to respond to member eligibility inquiries from providers

From time to time, NHP receives inquiries from medical providers about eligibility for coverage under the employer group's health plan. Under COBRA, employers have an obligation to respond to such inquiries. NHP's practice is to advise medical providers whether an individual is an active or inactive NHP member. However, NHP may also inform the provider that only the employer is able to give complete and definitive information on member eligibility due to retroactive enrollments or disenrollments that may relate to COBRA election or other events. Employers are required to respond to any such provider inquiry with information about a member's coverage, including any applicable COBRA election period.

Premium payment

As the employer, you are responsible for collecting premium payments for those individuals covered under COBRA. Under COBRA law, you are allowed to charge up to 102% of the group premium amount.

Subscribers whose coverage is extended from 18 to 29 months due to Social Security disability, may be required to pay up to 150% of the group premium amount after the 18 months.

If employees have questions

Questions concerning the plan or COBRA continuation coverage rights should be addressed to your plan administrator. For more information about a person's rights under ERISA including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's

Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.)

Keeping the plan informed of address changes

In order to protect the subscriber's rights, he/she should keep the plan administrator informed of any changes in the addresses of family members. Subscribers should also keep a copy for their records of any notices sent to the plan administrator.

Mini-COBRA under Massachusetts law (M.G.L. Chapter 176J Section 9)

"Mini-COBRA" is the Massachusetts law that establishes requirements for employers with 2–19 employees to provide continuation coverage for eligible employees and their eligible dependents. The coverage obligations under Mini-COBRA are essentially the same as those required by the federal COBRA statute. NHP requires all employers with 2–19 employees to provide eligible employees notice of their Mini-COBRA rights.

This notice of rights must be given to employees and their spouses, if applicable, (1) at the time of hire, and (2) within 14 days of the date of the qualifying event. You must allow employees 60 days from the qualifying event or date of notice, whichever is later, to elect continuation coverage. Additionally, you must notify NHP within 60 days of the qualifying event, and you must also notify NHP when the continuation period expires.

For more information on Mini-COBRA, visit the official Commonwealth of Massachusetts website at www.mass.gov.

QUESTIONS?

Call NHP's Customer Care Center 800-462-5449 (TTY 800-655-1761) Mon.–Fri., 8 a.m.–6 p.m., Thurs. 8 a.m.–8 p.m. | www.nhp.org

Continuation coverage for divorced or separated spouses

(M.G.L. Chapter 176G Section 5A and M.G.L. Chapter 175 Section 110I)

Massachusetts law requires all employer groups covered under an insured health plan in Massachusetts, including national employer groups, to provide continuation coverage through the employer group's health plan, at no additional premium, for divorced or separated spouses who otherwise would lose coverage due to loss of eligibility.

Coverage for divorced or separated spouses must continue through the employer group as long as the subscriber remains enrolled and until either the subscriber or the former spouse remarries (the only exception to this requirement must be established by a divorce decree). This coverage is available to the former spouse only while the subscriber continues to be an NHP member.

Upon remarriage of the subscriber, if the divorce decree requires the subscriber to continue to make coverage available to former spouse, NHP and the employer group must comply with the divorce decree. In this case, the former spouse may obtain identical benefits and rates either through:

- An individual policy under the employer group plan, or
- A special plan administered by, and payable directly to, NHP.

Continuation coverage due to plant closing or partial plant closing

(M.G.L. Chapter 176G Section 4A and M.G.L. Chapter 175 Section 110D and 110G)

Massachusetts law requires employer groups to provide continuation coverage for existing members who would otherwise lose coverage due to a plant closing or partial plant closing. Continuation coverage for plant closings must extend, at

the employer group's expense, for 90 days or until the member obtains similar coverage, whichever comes first. Employer groups are responsible for notifying employees of their continuation rights under this law.

Medicare secondary payer provisions

(42 U.S.C. Section 1395Y[B])

Employer groups offering group health coverage to Medicare beneficiaries are required to comply with Medicare Secondary Payer (MSP) rules established by CMS, the federal agency that administers the Medicare program.

Under these rules, Medicare is the secondary payer and the employer-sponsored health plan is the primary payer for the following categories of Medicare beneficiaries:

- The "working aged," meaning people who:
 - » Are eligible for Medicare on the basis of age.
 - » Are covered by an employer group health plan of an employer with 20 or more employees.
 - » Have such group coverage by virtue of their own current employment or the current employment of their spouse.
- People with disabilities, meaning people who:
 - » Are eligible for Medicare solely on the basis of disability (under age 65).
 - » Are covered by an employer group health plan of an employer with 100 or more employees.
 - » Have such group coverage by virtue of their own current employment or the current employment of a family member.
- People with permanent kidney failure or end stage renal disease (ESRD) who:
 - » Became eligible for Medicare on the basis of ESRD when they were under age 65, and
 - » Are covered by an employer group health plan of an employer of any size by virtue of

their own current or former employment or by the current or former employment of a family member. For persons in this category, Medicare is the secondary payer and the group health plan is the primary payer for the first 30 months of Medicare entitlement. Additionally, Medicare generally is the secondary payer for health services also covered by a Workers' Compensation law or plan, no-fault insurance (including automobile no-fault insurance), and any liability insurance policy or plan.

- Ensure primary payment is made when Medicare is the secondary payer.
- Ensure that there is no discrimination with respect to group health coverage for Medicare beneficiaries for whom Medicare is the secondary payer, and no incentive for such beneficiaries to reject group health coverage.
- Respond to "data match" inquiries from the Centers for Medicare and Medicaid Services.

The MSP provisions are highly technical. The above summary is intended as general information only. For specific information on MSP requirements and employer responsibility under MSP provisions, consult the company's legal counsel.

For information on MSP requirements, write to:

Address U.S. Department of Health and Human Services
 The Centers for Medicare and Medicaid Services
 6325 Security Boulevard
 Baltimore, MD 21207-5187

Employer MSP responsibilities

Employers have numerous responsibilities under the Medical Security Plan (MSP) laws. To fully understand MSP obligations, NHP encourages employers to consult with their legal counsel. The following is an overview of selected employer responsibilities under the MSP laws:

- Follow the MSP rules to correctly determine their number of employees.
- Identify Medicare beneficiaries (both active employees and retirees) to whom the MSP provisions apply.

Section 5

Coordination of benefits/ third-party liability

The NHP Coordination of Benefits (COB) Department determines when another insurer or party may be liable for expenses for services provided by NHP and coordinates benefits as allowed by law. Other coverage may include other health benefit plans, medical payment policies, governmental benefits and Medicare.

Benefits in the event of other coverage

When a member is covered by two or more health benefit plans, one plan will be “primary” and the other plan will be “secondary.” The benefits of the primary plan are determined before those of the secondary plan without considering the benefits of the secondary plan. The benefits of the secondary plan are determined after those of the primary plan and may be reduced because of the primary plan’s benefits.

In the case of health benefit plans that contain provisions for COB, the following rules shall decide which plan is primary and which plan is secondary:

- **Dependent/non-dependent**—The benefits of the plan that covers the person as an employee, or subscriber are determined before those of the plan that covers the person as a dependent.

A dependent child whose parents are not separated or divorced: The order of benefits is determined as follows:

- » The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in a year.
- » If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the

plan that covered the other parent for a shorter period of time.

- » However, if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in this plan (the “birthday rule”) will determine the order of benefits.
- **Dependent child/separated or divorced parents**—Unless a court order, of which NHP has knowledge, specifies one of the parents as responsible for the health-care benefits of the child, the order of benefits is determined as follows:
 - » First the plan of the parent with custody of the child.
 - » Then, the plan of the spouse of the parent with custody of the child.
 - » Finally, the plan of the parent not having custody of the child.
- **Active/inactive employee**—The benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.
- **Longer/shorter length of coverage**—If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, member, or subscriber longer are determined before those of the plan that covered that person for the shorter time. If a member is covered by a health benefit plan that does not have provisions governing the coordination of benefits between plans, that plan will be the primary plan.

Provider payment when NHP coverage is secondary

When a member’s NHP coverage is secondary to a member’s coverage under another health benefit plan, NHP may suspend payment to a provider of services until the provider has properly submitted

a claim to the primary plan and the claim has been paid, in whole or in part, or denied by the primary plan. NHP may recover any payments made for services in excess of NHP's liability as the secondary plan, either before or after payment by the primary plan.

Members eligible for Medicare

For a member who is eligible for Medicare by reason of end-stage renal disease, NHP will be the primary payer for covered services during the "coordination period" specified by federal regulations at 42 CFR Section 411.62. Thereafter, Medicare will be primary payer. When Medicare is primary (or would be primary if the member were timely enrolled) NHP will pay for services only to the extent payments would exceed what would be payable by Medicare.

- The *Member Handbook* provides more detailed information on coordination of payment in the event of other insurance. If members have more questions, they can call 617-772-5729 and ask for Coordination of Benefits.

Third-party liability (TPL)

Third-party liability (TPL) is a method of protecting NHP's rights of recovery in the event that another party is liable for payment of claims. The claims involved are generally related to an accidents such as automobile, slip and fall, work related injury, product liability, or medical malpractice. Once a claim has been identified as being the responsibility of another party, the TPL team protects our interest by either filing a lien, retracting the payments made or sending a bill to the other carrier.

Medical payment policies

For members who are entitled to benefits under the medical payment benefit of an automobile, motorcycle, boat, homeowners, hotel, restaurant, or other insurance policy, such coverage shall

become primary to the coverage under the *Member Handbook* for services rendered in connection with a covered loss under that policy. The benefits under the *Member Handbook* shall not duplicate any benefits to which the member is entitled under any medical payment policy or benefit. All sums payable for services provided under the *Member Handbook* to members that are covered under any medical payment policy or benefit are payable to NHP.

Workers' Compensation/ government programs

If NHP has information indicating that services provided to a member are covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state, or other governmental agency, NHP may suspend payment for such services until a determination is made whether payment will be made by such program.

If NHP provides or pays for services for an illness or injury covered under Workers' Compensation, employer's liability, or other program of similar purpose, or by a federal, state, or other government agency, NHP will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

Subrogation

Subrogation is a means by which NHP and other health insurance carriers recover expenses of services where a third party is legally responsible for a member's injury or illness.

If another person or entity is, or may be, liable to pay for services related to a member's illness or injury which have been paid for or provided by NHP, NHP will be subrogated and succeed to all rights of the member to recover against such person or entity 100% of the value of the services paid for or provided by NHP. NHP will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his

QUESTIONS?

Call NHP's Customer Care Center 800-462-5449 (TTY 800-655-1761) Mon.-Fri., 8 a.m.-6 p.m., Thurs. 8 a.m.-8 p.m. | www.nhp.org

liability carrier or the member's own auto insurance carrier.

In the event a member has been reimbursed by another party for medical expenses provided or paid for by NHP, NHP shall be entitled to recover from such member 100% of the amount the member has received. NHP's right to recover 100% of the value of services paid or provided is not subject to any reduction for attorney's fees. NHP's right to 100% recovery shall apply even if any recovery the member receives for an illness or injury is designated or described as being for damages other than health-care expenses.

To enforce its subrogation rights, NHP will have the right to take legal action, with or without the member's consent, against any party to secure recovery of the value of services provided or paid for by NHP for which such party is, or may, be liable. Nothing described herein shall be construed to limit NHP's right to utilize any remedy provided by law to enforce its rights to subrogation.

Member cooperation

The member agrees to cooperate with NHP in exercising its rights of subrogation and coordination of benefits under the *Member*

Handbook. Such cooperation will include, but not be limited to:

- The provision of all information and documents requested by NHP
- The execution of any instruments deemed necessary by NHP to protect its rights
- The prompt assignment to NHP of any monies received for services provided or paid for by NHP
- The prompt notification to NHP of any instances that may give rise to NHP's rights

The member further agrees to do nothing to prejudice or interfere with NHP's rights to subrogation or coordination of benefits. Failure of the member to perform the obligations stated in this subsection shall render the member liable to NHP for any expenses NHP may incur, including reasonable attorney's fees, in enforcing its rights.

NHP's rights

Nothing in this guide or the *Member Handbook* shall be construed to limit NHP's right to utilize any remedy provided by law to enforce its rights to subrogation or coordination of benefits.

Section 6

Claims

Submitting a claim

Neighborhood Health Plan (NHP) providers should not bill a member for any service included on the covered services list. But, if a member receives a bill from a provider, the member should send a copy of the bill to NHP at the address listed below. If a member paid an NHP provider for any service included on the covered services list the member should contact NHP's Customer Care Center and NHP will arrange to have the member reimbursed by the provider.

If a member needs emergency or urgent care while traveling abroad or out of the service area, NHP will pay the provider directly. Members should ask the provider to contact NHP to discuss payment if the provider asks the member for money. If a member does pay for emergency or urgent care while traveling abroad or out-of-state, NHP may reimburse the member.

Members must send a copy of the bill and proper receipts indicating payment to:

Address Neighborhood Health Plan
 Customer Care Center
 253 Summer Street
 Boston, MA 02210-1120

Send provider claims to NHP at the same address. Be sure to include the following information:

- Member's full name
- Member's date of birth
- Member's NHP member identification number
- Date the health-care service was provided
- A brief description of the illness or injury
- For pharmacy items, members must include:
 - » A dated drug store receipt stating the name of the drug or medical supply
 - » The prescription number
 - » The amount paid for the item

Limits on claims

NHP may reimburse members only for services that are emergency or urgent care benefits. There is a 12-month limit on how long an individual can take to submit a request for a reimbursement.

- All claims must be submitted in U.S. currency. NHP may require additional information for some claims.
- Members with questions about claims may call NHP's Customer Care Center:

Phone 800-462-5449
TTY 800-655-1761

Section 7

Member confidentiality and privacy of information confidentiality

NHP takes seriously our obligation to protect a member's personal and health information. In order to maintain a member's privacy, we have instituted the following practices:

- NHP employees do not discuss a member's personal information in public areas such as the cafeteria, on elevators, or when outside the office.
- Electronic information is kept secure through the use of passwords, automatic screen savers, and limiting access to only those employees with a "need to know."
- Written information is kept secure by storing it in locked file cabinets, enforcing "clean-desk" practices, and using secured shredding bins for its destruction.
- All employees, as part of their initial orientation, receive training on our confidentiality and privacy practices.
- All providers and other entities with whom we need to share information are required to sign agreements in which they agree to maintain confidentiality.
- NHP only collects information about a member that we need to have in order to provide the member with the services the member has agreed to receive by enrolling in NHP, or as otherwise required by law.

In accordance with state law, NHP takes special precautions to protect any information concerning mental health or substance abuse, HIV status, sexually transmitted diseases, pregnancy, or termination of pregnancy.

Notice of privacy practices

This section describes how health information about a member may be used and disclosed, and how a member can get access to this information. Please review it carefully. NHP provides health insurance coverage to members. Because members get health benefits from NHP, we have personal health information (PHI) about members. By law, NHP must protect the privacy of a member's health information.

This section explains:

- When NHP may use and share a member's health information.
- What a member's rights are regarding the member's health information.

NHP may use or share a member's health information:

- When the U.S. Department of Health and Human Services needs it to make sure a member's privacy is protected.
- When required by law or a law enforcement agency.
- For payment activities, such as checking if a member is eligible for health benefits, and paying the member's health-care providers for services the member receives.
- To operate programs, such as evaluating the quality of health-care services members receive, and performing studies to reduce health-care costs.
- With a member's health-care providers to coordinate the member's treatment and the services the member receives.
- With health-oversight agencies, such as the federal Centers for Medicare and Medicaid Services, for oversight activities authorized by law, including fraud and abuse investigations.

- For research projects that meet privacy requirements, and help us evaluate or improve NHP programs.
- With government agencies that provide a member with benefits or services.
- With plan sponsors of employer group health plans, but only if they agree to protect that information.
- To prevent or respond to an immediate and serious health or safety emergency.
- To remind a member of appointments, benefits, treatment options or other health-related choices the member has.

When state privacy law is stricter than federal privacy law, NHP will follow the stricter law.

For example, Massachusetts state law requires NHP to obtain a member’s written permission before sharing sensitive information such as HIV/AIDS or drug abuse.

Except as described above, NHP cannot use or share a member’s health information with anyone without the member’s written permission. A member may cancel permission at any time, as long as the member informs NHP in writing. (Please note that NHP cannot take back any health information we used or shared when we had the member’s permission.)

Members have the right to:

- See and get a copy of their health information. The member must request this in writing. NHP may charge the member to cover certain costs, such as copying and postage.
- Ask NHP to change their health information if the member thinks it is wrong or incomplete.

The member must inform NHP in writing which health information they want us to change, and why.

- Ask NHP to limit its use or sharing of the member’s health information. The member must request this in writing. NHP may not be able to grant this request.
- Ask NHP to get in touch with him/her in some other way, if by contacting the member at the address or telephone number we have on file, the member believes he/she would be harmed.
- Get a list of when and with whom NHP has shared the member’s health information. The member must request this in writing.
- Obtain a paper copy of this notice at any time.

These rights may not apply in certain situations. By law, NHP must give a member notice explaining that we protect the member’s health information, and that we must follow the terms of this notice.

NHP can change how we use and share a member’s health information. If NHP does make important changes, we will send members a new notice which will apply to all of the health information that NHP has about the member. NHP is strongly committed to maintaining member privacy. If a member would like to exercise any of the rights described in this notice, or if a member feels that NHP has violated his/her privacy rights, the member may contact NHP’s Privacy Officer in writing at:

Address Neighborhood Health Plan
 Privacy Officer
 253 Summer Street
 Boston, MA 02210-1120

QUESTIONS?

Filing a complaint or exercising a member's rights will not affect the member's benefits. The member may also file a complaint with the U.S. Secretary of Health and Human Services at:

Address U.S. Department of Health and
Human Services
200 Independence Avenue
SW Washington, DC 20201

Phone 202-619-0257

Toll-free 877-696-6775

For more information, or if a member needs help understanding this notice, the member can call NHP's Customer Care Center at 800-462-5449 (TTY 800-655-1761).

Section 8

Select federal and state health-care laws

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies to employer-sponsored health plans such as the plans offered by Neighborhood Health Plan (NHP). HIPAA applies to all group plans, regardless of size, and makes it easier for persons who change jobs to remain continuously covered under employer sponsored health plans while limiting restrictions due to pre-existing condition limitations.

A pre-existing condition limitation may only apply to medical advice, diagnosis, care or treatment recommended or received within six months of enrollment, and may only last for six months from enrollment.

HIPAA certificates

HIPAA requires health plans to provide “Certificates of Creditable Coverage” to show how many months of health-care coverage an individual had, up to a maximum of 18 months. The Certificate of Creditable Coverage also shows the date coverage ended. The purpose of a Certificate of Creditable Coverage is to prove to a new employer the number of months of “credit” a person has from a prior health plan.

If there has not been a gap in coverage of 63 days or more, any pre-existing condition exclusion period in a new employer’s health plan must be reduced by the number of days of coverage shown on the certificate. Certificates of Creditable Coverage must be provided at the following times:

- When an individual loses coverage under an employer sponsored plan, whether or not there is COBRA continuation coverage
- When coverage ends under COBRA (or similar state continuation provisions)
- Upon written request of a formerly covered individual within two years of loss of coverage consistent with these requirements, NHP sends out Certificates of Creditable Coverage whenever a member’s coverage with NHP (including COBRA coverage) ends and NHP has received a termination notice from the employer group or third party administrator acting on the employer’s behalf. NHP’s Customer Care Center also provides Certificates, free of charge, in response to requests from former members made within two years of the date coverage ends.

HIPAA Privacy Rule

HIPAA Privacy Rule requires NHP to provide individuals with an accurate and thorough description of possible uses and disclosures of their protected health information (PHI). NHP is committed to ensuring the utmost privacy and security protection of member/patient PHI. In accordance with the requirements defined by HIPAA, we will provide our members with a Notice of Privacy Practices, a document which describes permitted uses and disclosures of PHI, outlines an individual’s rights relating to their PHI and provides a description of how to file a complaint if the member feels there has been a breach of privacy.

HIPAA Security Rule

NHP is committed to maintaining the confidentiality and the security of electronic protected health information (PHI). Appropriate processes and procedures have been put in place to support the confidentiality, integrity and availability of PHI when interacting with our employer groups and/or their identified representatives.

QUESTIONS?

Call NHP’s Customer Care Center 800-462-5449 (TTY 800-655-1761) Mon.–Fri., 8 a.m.–6 p.m., Thurs. 8 a.m.–8 p.m. | www.nhp.org

For more HIPAA information, visit the Department of Labor website (www.dol.gov/ebsa), and the state of Massachusetts website (www.mass.gov/legis/laws/mgl/176j-1.htm).

Women’s Health and Cancer Rights Act of 1998

The Women’s Health and Cancer Rights Act (WHCRA) established specific benefits for women enrolled in group health plans. Consistent with the WHCRA requirements, the plan includes the following benefits with respect to a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses for reconstruction
- Coverage for physical complication of all stages of mastectomy, including lymph edemas

The above care must be provided in consultation with the physician and patient. NHP provides annual notice of these benefits to subscribers.

Newborns’ and Mothers’ Health Protection Act of 1996

Newborns’ and Mothers’ Health Protection Act of 1996 requires group health plans to permit newborns and their mothers to remain in the hospital for at least 48 hours in the case of a vaginal delivery or 96 hours in the case of a cesarean delivery. Any decision to shorten the inpatient stay for the mother and the newborn will be made by the mother in consultation with the attending physician.

Massachusetts Mental Health Parity Act

The Massachusetts Mental Health Parity Act (MHPA) requires Massachusetts health maintenance organizations (HMOs) and health insurance carriers to provide coverage for the certain biologically-based illnesses on a “parity basis,” meaning without annual or lifetime limits unless the same are imposed on benefits for physical conditions. Biologically-based mental disorders are defined as schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium, dementia, affective disorders, and any other biologically-based mental disorder appearing in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that is scientifically recognized and approved by the Commissioner of Mental Health.

MHPA also mandates parity coverage for the diagnosis and treatment of mental illnesses in children under age 19, and for the diagnosis and treatment of rape-related mental and emotional illnesses. Additionally, MHPA requires a minimum benefit of 60 days if inpatient treatment and a minimum benefit of 24 outpatient visits in a 12-month period for the medically necessary diagnosis and treatment of non-parity mental conditions.

Changes to the federal Mental Health Parity Law

The federal Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343, Subtitle B) goes into effect for large group health plans (51 or more employees) issued or renewed on or after October 3, 2009. In summary, the law includes the following:

- A health plan may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical/surgical benefits.

- A health plan may not have higher deductibles, copayments, coinsurance, out-of-pocket expenses, or more restrictive treatment limits (visits, days of coverage, or other similar limits on the scope or duration of treatment) for mental health or substance use disorders than those for medical/surgical benefits.
 - A preferred provider plan may not require that mental health or substance use disorder services be available solely from network providers.
-

Off-cycle enrollment rights

Under HIPAA, an employee who has declined enrollment for him/herself or dependents because of other health insurance coverage may enroll in the plan at any time if:

- The employee's spouse or eligible dependent has lost other insurance.
 - Employer contributions toward the dependent's coverage were terminated.
 - The employee marries.
 - The employee has a newborn or adoptive child.
 - The employee must submit a written request for enrollment to the employer within 30 days of one of the qualifying events listed above.
-

Section 9

Appendix

Contact information

NHP Mail Address

Neighborhood Health Plan
253 Summer Street
Boston, MA 02210-1120

NHP Coordination of Benefits/ Third Party Liability

Phone 617-772-5729

800-462-5449

Fax 617-526-1985

NHP Customer Care Center

Phone 800-462-5449

TTY 800-655-1761

Hours M–F, 8 a.m.–6 p.m.,
Th., 8 a.m.–8 p.m.

NHP Enrollment Department

Fax 617-526-1981

NHP Premium Payments

Neighborhood Health Plan
P. O. Box 844057
Boston, MA 02284-4057

NHP Sales Department

Phone 800-433-5556

Press 1 for English or 2 for Spanish,
then select option 4.

Fax 617-772-5509

Commonwealth of Massachusetts

www.mass.gov

Massachusetts Executive Office of Health and Human Services

www.mass.gov/eohhs

Medical Security Plan (MSP) Requirements

U.S. Department of Health and
Human Services
Centers for Medicare and
Medicaid Services
6325 Security Boulevard
Baltimore, MD 21207-5187

U.S. Secretary of Health and Human Services

U.S. Department of Health and
Human Services
200 Independence Avenue
SW Washington, DC 20201

Phone 202-619-0257

Toll-free 877-696-6775

How to find forms

To find the forms listed below, go to NHP's website at www.nhp.org.

- *Enrollment and Change Form*
- *Application for Coverage of Dependents Age 19–26*
- *Employee Health Insurance Responsibility Disclosure Form*

Employer Health Insurance Responsibility Disclosure

If you are an employer with a Massachusetts location and employ 11 or more full-time equivalent employees, you are required to file an *Employer Health Insurance Responsibility Disclosure* (Employer HIRD). The disclosure includes information about your compliance with the M.G.L. c. 151F requirement to adopt and maintain a Section 125 Cafeteria Plan.

You are also required to collect an *Employee Health Insurance Responsibility Disclosure* (Employee HIRD) from all employees that decline your offer of employer-sponsored insurance and/or participation in your Section 125 Cafeteria Plan.

To get information about where, how, when, and what to file, please visit the Massachusetts Executive Office of Health and Human Services website at www.mass.gov/eohhs. (To find the HIRD information page, type the letters "HIRD" into the search bar.)



Enrollment and Change Form

Tel 800-462-5449
Fax 617-526-1981

Please use a ballpoint pen and press down firmly.

Application for Enrollment

- New Employee
- Annual Enrollment
- COBRA Continuation
- Involuntary Loss of Prior Group Coverage *
- Other
- Termination
- Termination Effective Date: _____

Change in Enrollment

- Date: _____
- Adding Dependents
- Deleting Dependents
- Primary Care Physician / Site Change
- Other

Reason for Change in Enrollment

- Marriage
- Birth of Child
- Adoption of Child *
- Divorce
- Non-IRS Dependent
- * Documentation Required
- Left Employ
- Moved Out of Service Area
- Voluntary
- Loss of Dependent Eligibility
- Death (need exact date)
- Reached Age 65

Group Information

NHP Group Number

Employer Name							
Date of Employment	Month	Day	Year	Effective Date of Coverage	Month	Day	Year

If the Primary Care Physician (PCP) you choose is not in the NHP network, one will be selected for you. You may change your PCP assignment at any time.

Employee Information

Last Name				First Name				M.I.	Sex M/F
Date of Birth (mm/dd/yy)		Social Security Number		Home Phone - include area code			Work Phone - include area code		
Street Mailing Address				Apartment	PO Box	City		State	Zip Code

PCP and Site Information

Primary Care Site	Primary Care Site #
Your Primary Care Physician (Last, First, Middle Initial)	PCP #

Language

What Language do YOU speak most often? Please check the appropriate box. Knowing the main language spoken by you and your family members (see below) will help us to better serve your needs.

<input type="checkbox"/> 04 English	<input type="checkbox"/> 14 Spanish	<input type="checkbox"/> 05 French	<input type="checkbox"/> 06 Haitian Creole	<input type="checkbox"/> 12 Portuguese	<input type="checkbox"/> 13 Russian	<input type="checkbox"/> 03 Cape Verdean Creole	<input type="checkbox"/> 02 Cantonese	<input type="checkbox"/> 11 Mandarin	<input type="checkbox"/> 15 Vietnamese	<input type="checkbox"/> 16 Other, please specify
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Group Coverage

Type of NHP Coverage	<input type="checkbox"/> Self	<input type="checkbox"/> Individual/Spouse	In addition to NHP, my spouse or children are covered by a health plan offered by:	Effective Date							
Check one only	<input type="checkbox"/> Individual/ Child or Children	<input type="checkbox"/> Family	Employer:	Insurance Co./HMO Name:	Policy No.:	/ /					
Are you (and/or your spouse) eligible for Medicare:	<input type="checkbox"/> Self	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If 'yes' are you enrolled in:	Medicare Part A	Medicare Part B	Medicare Number	If 'yes' is your spouse enrolled in:	Medicare Part A	Medicare Part B	Your Spouse's Medicare Number

Please provide ALL information below for any eligible dependents you wish to enroll.

Spouse Last Name:	First Name	MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
Primary Care Site	Primary Care Site#	Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	
Dependent Last Name:	First Name	MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
Primary Care Site	PCP Site #	Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	
Dependent Last Name:	First Name	MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
Primary Care Site	PCP Site#	Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	
Dependent Last Name:	First Name	MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
Primary Care Site	PCP Site #	Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	
Dependent Last Name:	First Name	MI	Sex M/F	Social Security Number	Other Insurance	Date of Birth	IRS Dependent
Primary Care Site	PCP Site#	Primary Care Physician (Last Name, First Name, Middle Initial)			PCP #	Existing Patient	

Acknowledgement: The information supplied on this form is true and complete. I assign benefits to Neighborhood Health Plan (NHP) for the cost of services when the liability for payment is the responsibility of another plan/HMO, worker's compensation plan or other coverage. I (we) agree that NHP and its affiliated Health Care Providers, may obtain or release my (our) medical information including medical records, medical coverage available or other medical data for the purposes of administering benefits, evaluating medical care provided, conducting quality assurance reviews and analysis, conducting medical research, and/or as required by law. I (we) understand that for NHP coverage to be in effect when medical care supplies are obtained, all care and supplies must be authorized and provided by participating care physicians (as listed above).

Acuerdo: La información proporcionada en esta forma es veraz y completa. Asigno (asignamos) beneficios a NHP por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud/HMO, plan de compensación para trabajadores o otro tipo de cobertura. Estoy (estamos) de acuerdo que NHP y sus Proveedores de Cuidado de Salud afiliados pueden obtener o divulgar mi (nuestra) información médica, incluyendo registros médicos, cobertura médica disponible o otra información médica, con el propósito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médica y/o cuando es requerido por la ley. Yo entiendo (entendemos) que para que la cobertura de NHP tenga vigencia para la obtención de suministros médicos, toda la atención y todos los suministros deben ser autorizados y proporcionados por un médico de cuidado primario participante autorizado (según se indica arriba).

ALL INFORMATION MUST BE COMPLETED AND FORM SIGNED BEFORE PROCESSING CAN BEGIN

Employee's Signature:	Date:	Employer's Signature:	Date:
Contact Name: (Please print)	Telephone:		

Return this White Original to Neighborhood Health Plan - Yellow Copy to Employer - Pink Copy to Employee



Our mission

To promote the health and wellness of our members and to help ensure equitable, affordable health care for the diverse communities we serve.

