Exceptions Department
P.O. Box 9212
Chelsea, MA 02150

Date: **04/18/2008**
SSN: [redacted]
Notice: [redacted]

550/COM-EXC
L CC
1 MAIN
BOSTON MA 02111-0000

EXCEPTIONS FORM
COMMONWEALTH CARE

Dear L CC

The Connector needs more information to decide whether the following individual(s) are eligible for the Commonwealth Care Health Insurance Program.

Name	**SSN/DOB**
CC, MRS	[redacted]

Reason and Manual Citation
You told us that your employer offered health insurance within the past six months. Persons who can get subsidized insurance from their employer are not eligible for Commonwealth Care (see 956 CMR 3.09). But you may get Commonwealth Care right away if you meet one of the exceptions listed below.

Please put a checkmark in the space next to the letter (A, B, C, or D) of the exception that you think you meet. You may need to contact the employer who offered this health insurance to find out how much they pay for the health-plan premiums they offered you. You must sign below. Return this form to the address below. You will get another letter when the Connector makes a new decision.

( ) A. The employer who offered health insurance pays for less than 20% of the annual premium costs for a family plan.
( ) B. The employer who offered health insurance pays for less than 33% of the annual premium costs for an individual plan.
( ) C. Your employer pays for at least 20% of the annual premium costs for a family plan or pays for at least 33% of the annual premium costs for an individual plan, but you are in a waiting period before this insurance begins. Date employer insurance begins: ___/___/___

( ) D. You do not work enough hours to be eligible for the health insurance offered by your employer. Number of scheduled hours worked per week: _____

If you do not claim that you meet any of these exceptions by checking any of these boxes and sending this form to the address below, then

this notice is a final decision by the Connector that you are not eligible for Commonwealth Care coverage. You have a right to appeal this decision and get a hearing before an impartial hearing officer. To ask for a hearing, complete the enclosed form according to the enclosed instructions and return it to the Connector. The Connector must get the form within 30 days of when you get this notice. We expect that you got this notice within three days after the date of this notice.

You may be eligible for certain services from MassHealth or the Health Safety Net.You will receive another notice explaining what is available under those programs.

Employee name: _____

Employer name: _____

Employer address: _____

_____

Employer phone number: _____

By signing this document, I allow my employer listed above to give MassHealth, the Commonwealth Care Health Insurance Program, and its vendors information about premiums, coinsurance, deductibles, and covered benefits that are or may be available to me through my employment.

_____ _____

Signature of applicant/member or eligibility representative **Date**

Return this signed form to:
Exceptions Department, P.O. Box 9212, Chelsea, MA 02150