

---

TUFTS  Health Plan

Massachusetts

**Employer Group Fully-Insured  
CareLink<sup>SM</sup>  
Administrative Manual**

---

---

September 2010

---

Copyright © 2010 by Tufts Associated Health Plans, Inc.

All rights reserved. No part of this book may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission from Tufts Associated Health Plans, Inc.

Tufts Health Plan  
 705 Mount Auburn Street  
 Watertown, MA 02472

Document Revision History			
Revision Number	Content Owner	Approval	Approval Date
1	Sales and Services	Michele Lowe, Manager Sales Program, Sales & Services	7/1/08
2	Sales and Services	Michele Lowe, Manager Sales Program, Sales & Services	7/1/09
3	Sales and Services	Michele Lowe, Manager Sales Program, Sales & Services	1/1/10
4	Sales and Services	Michele Lowe, Manager Sales Program, Sales & Services	9/23/10

# Table of Contents

<b>Chapter 1</b>	<b>Introduction</b> .....	7
	About Tufts Health Plan and the CareLinkSM Fully-Insured Product .....	7
	Level of Benefits .....	8
	National Provider Network .....	8
	In-Network Level of Benefits .....	8
	Out-of-Network Level of Benefits .....	8
	Emergency Medical Coverage .....	8
	Visit Our Web Site .....	8
	Special Member Needs .....	9
	Translation Services .....	9
	Services for the Hearing Impaired .....	9
<b>Chapter 2</b>	<b>Administering Your Plan</b> .....	11
	Enrollment Service Area .....	11
	Enrollments .....	11
	Web Enrollment .....	11
	Electronic Enrollment .....	11
	Paper Enrollment .....	12
	Medicare Secondary Payer Information .....	13
	Qualifying Events for Adding Employees .....	13
	Enrollment Transaction Forms .....	15
	Member Change Form .....	15
	Dependent Certification Form .....	15
	Terminations .....	15
	Submission Timeline (60-Day Rule) .....	16
	Terminations Exceeding the Timeline .....	16
	Enrollments Exceeding the Timeline .....	16
	Summary of Forms .....	16
	Sample Forms .....	17
<b>Chapter 3</b>	<b>Dependent Eligibility</b> .....	25
	Dependent Certification Policy .....	25
	Adopted Child Policy .....	26
	Disabled Dependent Policy .....	26
	Enrollment Process .....	26
	Domestic Partners Policy .....	26
	Eligibility .....	26
	Dependent Children .....	27
	Enrollment/Disenrollment .....	27
	Continuation of Coverage for Domestic Partners .....	27

	Other Conditions . . . . .	27
	Michelle's Law . . . . .	27
	Changing the Type of Coverage . . . . .	28
	Qualifying Events for Adding Dependents . . . . .	28
<b>Chapter 4</b>	<b>Continuation of Coverage</b> . . . . .	31
	COBRA . . . . .	31
	COBRA Policies . . . . .	31
	Length of Eligibility . . . . .	31
	COBRA Administrative Steps . . . . .	31
	Termination from Medical Coverage . . . . .	32
	Reinstatement . . . . .	32
	Termination from COBRA . . . . .	32
	Notice Requirements . . . . .	32
	Individual Coverage . . . . .	32
<b>Chapter 5</b>	<b>Premium Billing</b> . . . . .	33
	Premium Billing Invoices . . . . .	33
	Online Billing . . . . .	33
	Premium Billing Policies . . . . .	34
	Additions to the Plan . . . . .	34
	Terminations from the Plan . . . . .	34
	Remittance . . . . .	34
	Wire Payment . . . . .	34
	Online Payment . . . . .	34
	Correspondence . . . . .	35
	Reading the Premium Bill . . . . .	35
	Statement of Account and Returnable Coupon . . . . .	35
	Explanation of Invoice . . . . .	35
	Transaction Types . . . . .	35
	Important Updates . . . . .	35
	Toll-Free and Fax Numbers . . . . .	36
	Details of Premium Bill . . . . .	36
	Reminder and Termination Letters . . . . .	42
<b>Chapter 6</b>	<b>Member Information</b> . . . . .	43
	Member Materials . . . . .	43
	Membership ID Card . . . . .	43
	Benefit Document . . . . .	43
	Online Member Benefits . . . . .	44
	CareLink Provider Directory . . . . .	44
	Caremark® Mail Service Order Form . . . . .	44
	Massachusetts 1099-HC Form Information . . . . .	44
	Member Satisfaction . . . . .	44
	Appeals Process . . . . .	44
	Grievance Process . . . . .	45

Additional Information . . . . . 45  
Reminder and Termination Letters . . . . . 45



# 1 Introduction

Welcome to the Tufts Health Plan<sup>®</sup> Employer Group CareLink<sup>SM</sup> Administrative Manual. Designed to serve as a guide for administering Tufts Health Plan at your company, this manual answers questions about the Plan and explains procedures you need to know.

We think you will find Tufts Health Plan easy to administer. However, there may be instances when this manual will not contain the answer to your question. In these cases, your account representative and other Tufts Health Plan personnel are available to assist you by calling one of the following numbers:

- (617) 923-5406 Watertown, MA
- (800) 208-8013 Watertown, MA
- (800) 208-9545 Worcester, MA
- (800) 337-4447 Springfield, MA

## About Tufts Health Plan and the CareLink<sup>SM</sup> Fully-Insured Product

Tufts Health Plan has joined forces with CIGNA HealthCare to offer CareLink, a national, open access health plan that gives multi-state employers the advantage of working with experienced health care leaders committed to helping you achieve affordable coverage for all of your employees, regardless of where they live.

With CareLink, you and your employees across the country have the benefit of working with one claims office, and one member services department, providing streamlined administration and consistent, high-quality service.

Tufts Health Plan has a strong focus on quality and customer service. We offer the kind of coverage and service that our members expect: thousands of doctors from our extensive provider network, 24-hour worldwide emergency care, outstanding customer service, comprehensive benefits coverage, and a dedication to quality.

The CareLink option allows the member to choose from two levels of coverage when obtaining medical services. The in-network level of benefits applies when a member receives care from providers within the CareLink network. The out-of-network level of benefits applies when a member chooses to receive care from providers who are not part of the CareLink provider.

Our member service specialists can help a member find a network provider. Specialists are available at 1-866-352-9114. A member can also access our Web site at [www.tuftshealthplan](http://www.tuftshealthplan) to find network providers.

## Level of Benefits

### National Provider Network

Members have access to a broad regional and national provider network of more than 420,000 physicians and 4,200 hospitals. In general, when members choose to access in-network care in Massachusetts and Rhode Island, they need to choose a provider from the Tufts Health Plan network. When members choose to access in-network care in all other states, they need to choose a provider from the CIGNA provider network.

CareLink members can obtain health care from: 1) a provider within the national CareLink provider network or 2) any other health care provider. A member's choice determines the level of benefits he/she receives for health care services.

### In-Network Level of Benefits

If a member receives care from providers within the national CareLink provider network (physicians, hospitals, and other providers), the member is responsible for paying any applicable deductible, copayment, and/or coinsurance for services.

If a CareLink member requires inpatient mental health or inpatient substance abuse services, he/she can go to any CareLink provider network facility and receive coverage at the in-network level of benefits<sup>1</sup>.

CareLink provider network mental health facilities are part of the Tufts Health Plan provider network in Massachusetts and Rhode Island, and part of the CIGNA provider network in the rest of the country.

### Out-of-Network Level of Benefits

If a member chooses to receive care from providers who are not part of the national CareLink provider network, he/she pays a deductible for covered services in each benefit year if out-of-network services are covered under the member's plan. Once the deductible is satisfied, the member pays coinsurance for all covered services up to the out-of-pocket maximum. After a member reaches the out-of-pocket maximum, he/she is covered in full for usual and customary charges for all covered services in that calendar year. Members are responsible for any excess above the usual and customary charges. Finally, members may be required to submit a Member Reimbursement Form for each out-of-network service provided by an out-of-network provider, if the provider does not submit a claim.

In the case of inpatient mental health and inpatient substance abuse services, if a member goes to an out-of-network facility, coverage is at the out-of-network level of benefits.

### Emergency Medical Coverage

Tufts Health Plan members are always covered for an emergency, no matter where they are or what time it is. Please see the benefit document for a description of an emergency.

## Visit Our Web Site

The Tufts Health Plan Web site is located at [www.tuftshealthplan.com](http://www.tuftshealthplan.com). Information on the Web site includes:

---

<sup>1</sup> A deductible may apply.

- How to contact Tufts Health Plan
- How members can get the most from their Plan membership
- Web enrollment
- How to change an address<sup>2</sup>
- How to find a network provider
- Health topics
- Issues relating to employers, brokers, and consultants

## Special Member Needs

### Translation Services

Member services specialists have access to AT&T's Language Line, which allows a non-English speaking member, professional interpreter, and member services specialist to conduct a three-way conversation. Interpreters are available for more than 140 languages.

If a member needs an interpreter, he or she can call a member services specialist at 866-352-9114.

### Services for the Hearing Impaired

Tufts Health Plan's Member Services department is equipped with a telecommunication device for the deaf (TTY). Hearing impaired members with TTY capabilities can call 800-868-5850 to communicate with a member services specialist. The specialist can also help the member select a PCP who knows American Sign Language.

---

<sup>2</sup> This functionality is available to members whose groups have requested it.



## 2 Administering Your Plan

This section provides information on enrollment service areas, enrollments, qualifying events, and forms. See [Forms](#) for sample forms and related information.

### Enrollment Service Area

The Tufts Health Plan service area includes a primary and extended service area for the CareLink health plan includes the 50 United States, but does not include Puerto Rico.

### Enrollments

Eligible employees and dependents can enroll in Tufts Health Plan within 30 days of their eligibility effective date

Members eligible for Dependent Coverage or covered under a Qualified Medical Child Support Order (QMCSO) are eligible for CareLink coverage, as stated in the benefit document (see [Chapter 3, Dependent Eligibility](#)). Members eligible for COBRA are eligible for CareLink m

The employer is responsible for making decisions regarding the eligibility of employees and dependents. Tufts Health Plan reserves the right to request reasonable documentation in order to validate a member's eligibility in support of an enrollment.

### Web Enrollment

Tufts Health Plan's web enrollment process allows you to enroll employees and perform plan administration online. Using web enrollment, you can:

- Review, verify, and submit enrollment transactions
- Add/delete dependents during qualifying events
- Obtain transaction data for a selected time period

### Electronic Enrollment

Tufts Health Plan offers a HIPAA-compliant electronic data interchange (EDI) program that enables employer groups to send eligibility data electronically. Tufts Health Plan can accept either of the following:

- HIPAA-compliant transaction files (additions, terminations, and changes since the last file submission)
- Full HIPAA-compliant files with terminations (all members covered by Tufts Health Plan for that employer group)

Both file types will be updated directly into Tufts Health Plan's membership system. This automated process enables Tufts Health Plan to:

- Process most transactions without manual intervention
- Produce a confirmation report of transactions performed through this process
- Produce a report of transactions that require manual intervention and follow-up
- Confirm that the employer group's list of Tufts Health Plan enrollees is consistent with Tufts Health Plan's records

For additional information, either call 1-888-880-8699, extension 4030 or contact your account manager.

## Paper Enrollment

To enroll an employee without using electronic means, you may submit a completed Member Enrollment Form to Tufts Health Plan. Incomplete or incorrectly completed forms delay the enrollment process. Once the forms are complete, you must send them to Tufts Health Plan's Enrollment department within 60 days of the qualifying event<sup>3</sup>.

If Tufts Health Plan is not notified within this 60-day time frame, the member is not eligible to enroll until the next open enrollment or upon the occurrence of another qualifying event, whichever occurs first.

### Completing the Member Enrollment Form

If your employee is a new hire, the coverage effective date is the day after your plan's waiting period (if any) has been satisfied. The documents necessary to complete enrollment are described in [Qualifying Events for Adding Employees](#).

#### **Member Section**

To enroll in Tufts Health Plan, members must complete and sign the member section on the Member Enrollment Form.

To find a CareLink network provider, members can use the Provider Search tool on the Tufts Health Plan Web site ([www.tuftshealthplan.com/carelink](http://www.tuftshealthplan.com/carelink)) or call member services for assistance.

#### **Employer Section**

You must ensure that the following information is provided on the completed Member Enrollment Form:

- Group number (box 2)
- Date of hire (box 3)
- Effective date of coverage (box 4)
- Type of enrollment (box 6)
- Qualifying event date (box 7)
- Social Security Number of all subscribers and dependents enrolling in Tufts Health Plan

Once the form is complete, review it for completeness, and sign and date it. Then distribute the copies of the completed form as follows:

- Original – Tufts Health Plan

---

<sup>3</sup> Qualifying events are specific events (see [Qualifying Events for Adding Employees](#)) that qualify an employee to enroll in Tufts Health Plan.

- Pink – employer’s files
- Yellow – employee<sup>4</sup>

## Medicare Secondary Payer Information

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees the Medicare program. There are federal rules that determine who pays claims first for Medicare beneficiaries who also have group health plan coverage in addition to Medicare. These rules are known as the Medicare Secondary Payer rules.

Starting January 1, 2009, Tufts Health Plan is required to report group and member information to CMS related to group health plan coverage. Based on this mandatory reporting, Tufts Health Plan will require a social security number for each member and a tax identification number and employer size for each employer. The employer size includes all full-time and part-time employees (regardless of benefits eligibility) and is the factor used to determine the primary payer for a Medicare beneficiary's claims, therefore, employers will be asked to validate employer size at least annually. Please contact your Account Manager if you have questions related to Medicare Secondary Payer requirements.

## Qualifying Events for Adding Employees

When the following events<sup>5</sup> occur, employees qualify to enroll in Tufts Health Plan and must send the appropriate documents to Tufts Health Plan to initiate the enrollment process

Qualifying Event	Description	Necessary Documents
Open Enrollment	The open enrollment date (generally coincides with the group’s anniversary date) when all eligible employees are given the opportunity to enroll or amend their current enrollment status.	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul>
New Hire	A new employee who meets the employer’s qualifications for health benefits.	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul>

<sup>4</sup> The yellow employee copy serves as a temporary ID card until the member receives his or her Tufts Health Plan ID card. The temporary ID card cannot be used at a pharmacy. If a member needs a prescription filled, they must call a Tufts Health Plan member services specialist at 866-352-9114.

<sup>5</sup> Qualifying events for dependents are reviewed in [Dependent Eligibility](#).

Qualifying Event	Description	Necessary Documents
Rehire	An employee who is rehired and meets the employer's qualifications for health benefits.	<p>Less than 60-day gap between the termination and rehire date:</p> <ul style="list-style-type: none"> <li>• Completed Member Change Form only</li> </ul> <p>Greater than 60-day gap between the termination and rehire date: Note: Member could have to resatisfy a waiting period, if one exists.</p> <ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> <li>• Completed Member Change Form</li> </ul>
Special Enrollment	Addition of a group or a new member initiated by such events as mergers and acquisition. Tufts Health Plan's underwriting department must approve all special enrollments.	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> <li>• Completed Member Change Form</li> </ul>
HIPAA or Section 125 Special Enrollment	Subscriber experiences a HIPAA/Section 125 qualifying event.	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> <li>• Completed Member Change Form</li> </ul>
Loss of Coverage	Employee has lost coverage with previous insurance company.	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul>
Move into the Service Area	Employee moves into or out of CareLink national service area. Coverage is effective on the date the employee establishes residency in the service area. Dependents are eligible to enroll if and when they move into the service area (see Dependent Eligibility)	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul>
Full-time Status Upgrade	Employee moves from part-time to full-time employment. Effective date is the date the employee becomes full-time, assuming the employee has satisfied any applicable waiting period. If the employee has not satisfied the waiting period, the effective date is the date the employee satisfies the waiting period.	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul>

Employees must complete a Member Enrollment Form within 30 days of these qualifying events. Employers have an additional 30 days (for a total of 60 days from the qualifying event) to submit documentation to Tufts Health Plan.

If Tufts Health Plan is not notified within this 60-day time frame, the employee is not eligible to enroll until the next open enrollment, or upon the occurrence of another qualifying event, whichever occurs first.

Tufts Health Plan only allows product changes for the following events<sup>6</sup>:

- Open enrollment
- Move into or out of the service area
- HIPAA/Section 125 Special Enrollment

## Enrollment Transaction Forms

### Member Change Form

You can use the Member Change Form on its own to communicate to Tufts Health Plan the following changes:

- Change member's name, address, or telephone number
- Reinstatement of membership for COBRA/State Continuation of Coverage (CoC)
- Termination of coverage
- Dependent changes

### Dependent Certification Form

To obtain coverage for a dependent "child" (as defined in the benefit document) over the age of 21 meeting Tufts Health Plan's criteria, the subscriber must complete and sign a Dependent Certification Form. For additional information, refer to the Dependent Certification Policy in [Dependent Eligibility](#).

## Terminations

Employees are terminated from the Plan if they discontinue employment, drop coverage, no longer qualify for benefits, lose coverage, or are terminated by Tufts Health Plan as provided in the benefit document. Terminations can become effective on any date. Employer retroactive terminations cannot be effective more than 60 days before the date the Enrollment or Premium Billing department receives the termination request. To process a termination, Tufts Health Plan must receive a Member Change Form within 60 days of the coverage end date.

If Tufts Health Plan is not notified within this 60-day time frame, the member's effective date of termination is equal to 60 days prior to the date that Tufts Health Plan received the request. This includes misrepresentation of eligibility information.

**Note:** Tufts Health Plan may terminate the group's coverage for misrepresentation or fraud with a retroactive time period in excess of 60 days.

---

<sup>6</sup> Only applies to employers offering more than one product.

## Submission Timeline (60-Day Rule)

The effective date of any change cannot be more than 60 days before the date Tufts Health Plan receives the written request. This rule applies when terminating subscribers or dependents from membership or when adding<sup>7</sup> new subscribers or dependents.

### Terminations Exceeding the Timeline

If a group requests a termination that exceeds the timeline of this rule, Tufts Health Plan will process the termination, but the date of termination will be equal to 60 days prior to the date that Tufts Health Plan received the request. If the termination date is changed, you will be notified. You are not entitled to any reimbursement of any premium paid for the period prior to 60 days before Tufts Health Plan received the termination notice.

### Enrollments Exceeding the Timeline

If a group attempts to enroll a member with an effective date that exceeds this 60-day timeline, Tufts Health Plan will deny the request in writing and return the documents to you.

If Tufts Health Plan is not notified within this 60-day time frame, the member is not eligible to enroll until the next open enrollment, or upon the occurrence of another qualifying event, whichever occurs first.

## Summary of Forms

The following section summarizes and describes the use of the most common Tufts Health Plan forms. It is important to complete forms properly. Submitting incomplete forms delays the applicable transactions.

Form	Purpose	Steps
Member Enrollment Form	<ul style="list-style-type: none"> <li>• Enroll members in plan</li> <li>• Add dependents</li> <li>• Change type of coverage, e.g., Individual to Family or Family to Individual</li> </ul>	<p>Member section:</p> <ul style="list-style-type: none"> <li>• Complete form</li> </ul> <p>Employer section:</p> <ul style="list-style-type: none"> <li>• Enter group number</li> <li>• Enter effective coverage date, type of enrollment and date of employment</li> <li>• Review form for completeness</li> <li>• Sign and date the Member Enrollment Form</li> <li>• Distribute sheets as appropriate – send white copy to Tufts Health Plan</li> </ul>
Member Change Form	<ul style="list-style-type: none"> <li>• Member name, address or telephone changes</li> <li>• Dependent changes</li> <li>• Reinstatement of membership for COBRA/COC coverage</li> <li>• Coverage termination</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure form is complete</li> <li>• Ensure reason code is correct</li> <li>• Send white copy to Tufts Health Plan</li> </ul>

<sup>7</sup> New additions must experience a valid qualifying event.

Form	Purpose	Steps
Member Reimbursement Form	<ul style="list-style-type: none"> <li>To file for reimbursement for services provided by a non-CareLink plan provider</li> </ul>	<p>Member's responsibility</p> <ul style="list-style-type: none"> <li>Ensure that the form is complete</li> <li>Send the completed form to Tufts Health Plan</li> </ul>
Dependent Certification Form	<ul style="list-style-type: none"> <li>Confirm status for dependents between the ages of 21 and 26</li> <li>Request reimbursement for out-of-pocket prescription expenses</li> </ul>	<ul style="list-style-type: none"> <li>Subscriber completes and signs the form</li> <li>Subscriber returns the form to Tufts Health Plan's enrollment department within 30 days of request</li> </ul>
Caremark® Prescription Reimbursement Standard Claim Form (if your plan provides prescription coverage)	<ul style="list-style-type: none"> <li>Request reimbursement for out-of-pocket prescription expenses</li> </ul>	<ul style="list-style-type: none"> <li>Member completes form</li> <li>Send form to Caremark® (the address is stated on the claim form)</li> </ul>
Caremark® Mail Service Order Form (if your plan provides prescription coverage)	<ul style="list-style-type: none"> <li>Obtain up to a 90-day supply of maintenance medicine at one time - typically provides copayment savings to members</li> </ul>	<ul style="list-style-type: none"> <li>Member requests doctor to write a new prescription (up to a 90-day supply, with up to three 90-day refills, if appropriate)</li> <li>Complete the Patient Profile/Mail Service Order form</li> <li>Mail the form, the original prescription, and payment to: Caremark P.O. Box 2110 Pittsburgh, PA 15230-2100</li> <li>Prescriptions are delivered 10 to 14 days from the date the order was mailed</li> </ul> <p>For refills, do one of the following:</p> <ul style="list-style-type: none"> <li>Call Caremark at 888-424-6618</li> <li>Mail in a new order form to Caremark with payment</li> <li>Order refills online at <a href="http://www.caremark.com">www.caremark.com</a></li> </ul>

## Sample Forms

The following pages contain samples of the most common Tufts Health Plan forms.

## MEMBER ENROLLMENT FORM

Please print or type. Please be sure application is completed in full to ensure enrollment.

Enrollment/Eligibility • PO Box 9186 • Watertown, Massachusetts 02471-9186

### Employer Section

FAILURE TO COMPLETE AREAS MARKED IN BLUE MAY CAUSE A DELAY IN ENROLLMENT.

1. Name of Employer or Group		2. Group Number		3. Date of Hire		4. Effective Date of Coverage	
5. Office Location		6. Type of Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> New Group <input type="checkbox"/> Qualifying Event (MUST specify) _____				7. Qualifying Event Date	

### Member Section

PRODUCT (Select corresponding letter from the list on the front page) \_\_\_\_\_ Other \_\_\_\_\_

Have you or anyone in your household used tobacco products, e.g., cigarettes, chewing tobacco, etc., in the last 12 months?  Yes  No

8. Last Name			9. First Name			10. Middle Initial		11. Employee Social Security Number (SSN)		
12. Mailing Address (Home address)			13. Apt#	14. City		15. State	16. ZIP		17. Gender <input type="checkbox"/> M <input type="checkbox"/> F	18. Date of Birth / / Birth month day year
19. Home Telephone ( )		20. Work Telephone ( )		21. Fitness Center			22. Primary Language			
23. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner				24. Type of Coverage Requested <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Other _____						
25. Primary Care Provider (HMO, POS, EPO only) First Name _____ Last Name _____				26. PCP ID#		27. Are you an established patient of this PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Members Enrolling (Last name, if different)	Sex M/F	Date of Birth	If dependent is over age 19, please check one		Social Security Number	Fitness Center	Choose a Primary Care Provider for each member (HMO/POS/EPO only)		Check if currently used for primary care	PCP ID#
			Full time Student	Disabled			First Name	Last Name		
28. Spouse/DP					- -					
29. Child/Dependent					- -					
30. Child/Dependent					- -					
31. Child/Dependent					- -					
32. Child/Dependent					- -					
33. Child/Dependent					- -					

34. Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? <input type="checkbox"/> Yes <input type="checkbox"/> Yes (Medicare) <input type="checkbox"/> No		Name of Health Plan	Name of Plan Holder	Health Plan Number	Effective Date	Names of Family Members Covered
35. Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Name and Address of Employer				
36. Please check if you are using additional membership applications for additional dependent children. <input type="checkbox"/>						

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payment directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the member services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.


Signature (required): \_\_\_\_\_ Date: \_\_\_\_\_ Benefits Dept. Signature: \_\_\_\_\_ Telephone: \_\_\_\_\_ Date: \_\_\_\_\_

WHITE - TUFTS HEALTH PLAN COPY

PINK - EMPLOYER COPY

YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.

FIGURE 2-1. Member Enrollment Form

**TUFTS  Health Plan**  
*No one does more to keep you healthy.*

**MEMBER CHANGE FORM**  
(Please see reverse side)

Please complete the summary and submit it  
with the applications and changes it reflects to:  
TUFTS HEALTH PLAN  
P.O. BOX 9186  
WATERTOWN, MA 02471-9186  
FAX 617-923-5898

Submitted By:	Date Submitted:	
Name of Employer Group:	Group Number:	Telephone Number:

1. Name of Member (Last, First, MI)	2. Member No.	3. Plan Code	4. Action Code	5. Effective Date	6. Additional Information
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					

**FIGURE 2-2.** Member Change Form



## DEPENDENT CERTIFICATION FORM FOR MASSACHUSETTS BASED EMPLOYER GROUPS

TUFTS  Health Plan

Subscriber's name: \_\_\_\_\_

Subscriber's Tufts Health Plan ID number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I certify that: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Name of dependent) (Date of Birth)

### Please check one:

Is currently a FULL-TIME STUDENT

At: \_\_\_\_\_ (Name of accredited educational institution)  
\_\_\_\_\_ (Institution address)  
\_\_\_\_\_ (Institution City, State and Zip)  
\_\_\_\_\_ (Registrar's telephone number)

Expected date of graduation from college: \_\_\_\_\_ / \_\_\_\_\_ (if graduating this year, please complete the statements below)

Is NOT A FULL-TIME STUDENT

If not a full-time student, please complete the statements below so that Tufts Health Plan can determine the coverage end date applicable under Massachusetts and/or Federal Law.

\_\_\_\_\_ The above named person last qualified as a dependent as defined under the Internal Revenue Service (IRS) code during calendar year\* \_\_\_\_\_

\_\_\_\_\_ The dependent has a medical condition that resulted in a medically necessary leave of absence from, or change in enrollment at a post secondary educational institution.\*\* This leave started on \_\_\_\_\_  
(A completed physician certification form must be submitted. This form can be found at [www.tuftshealthplan.com](http://www.tuftshealthplan.com))

**I further certify that the information I have provided above is true and correct, and that I understand that:**


- Tufts Health Plan may contact the educational institution and take any other steps it feels necessary to verify the accuracy of the information I have provided.
- If there is any misrepresentation in the information I have provided, Tufts Health Plan may end my dependent's coverage as well as my entire family's coverage, and may seek any other legal remedies available.

Subscriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Must be Employee's signature)

Please return this completed and signed form to:  
Tufts Health Plan  
Commercial Enrollment and Premium Billing Department  
P. O. Box 9186, Watertown, MA 02471-9186  
Fax: 617-923-5898

continued on reverse

Figure 2-4: Dependent Certification Form




## MAIL SERVICE ORDER FORM

Please fold here

↓

Mail order form to:

  
 CAREMARK  
 PO BOX 2110  
 PITTSBURGH, PA 15230-2110

Please fold here

↓

Enter ID # below if not shown or if different from above

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Use this form to order NEW and/or REFILL mail service prescriptions. Please print in **BLUE** or **BLACK INK** using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at [www.caremark.com](http://www.caremark.com) or call toll-free 1-888-424-6618.

Address Change/Shipping Information (Complete **ONLY IF DIFFERENT** or not shown above)

Last Name	First Name	MI	Suffix (JR, SR)
<table border="1" style="width: 100%; height: 15px;"></table>	<table border="1" style="width: 100%; height: 15px;"></table>	<table border="1" style="width: 100%; height: 15px;"></table>	<table border="1" style="width: 100%; height: 15px;"></table>
Street Address	Apt./Suite#	Use this address for this order only.	
<table border="1" style="width: 100%; height: 15px;"></table>	<table border="1" style="width: 100%; height: 15px;"></table>		
City	State	Zip Code	
<table border="1" style="width: 100%; height: 15px;"></table>	<table border="1" style="width: 100%; height: 15px;"></table>	<table border="1" style="width: 100%; height: 15px;"></table>	
Prescription Plan Sponsor or Company Name	Daytime Phone#:	<table border="1" style="width: 100%; height: 15px;"></table>	
	Evening Phone#:	<table border="1" style="width: 100%; height: 15px;"></table>	

NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.

If space is needed for more refill labels, you may: 1) attach labels to a blank piece of paper and send with this order form, or 2) print a Refill Order Continuation Form at our Web site above, or 3) call Caremark Customer Care at the toll-free number above.

Please fold here

↓

Apply Caremark Refill Label here

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

or

write prescription number above

Please fold here

↓

Apply Caremark Refill Label here

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

or

write prescription number above

Please fold here

↓

Apply Caremark Refill Label here

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

or

write prescription number above

Please fold here

↓

Apply Caremark Refill Label here


--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

or

write prescription number above

Visit [www.caremark.com](http://www.caremark.com) for the fastest refills. Log in to check order status and access personalized information about your prescription benefits. **IMPORTANT NOTICE:** When getting a new prescription, be sure to ask your doctor to write your prescription for the maximum amount allowed by your benefit plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions.

Unless otherwise directed, all prescriptions received on a single order form or in a single envelope may be shipped together in one package.  
**Please turn over to provide additional information.**



©2007 Caremark. All rights reserved.

Figure 2-5: Caremark® Mail Service Order Form

**Fill in for up to two individuals who will receive prescriptions with this order.**

**#1:**  Easy open caps  Print materials in Spanish

Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth: --

E-mail Address:  Date new prescription(s) received from doctor:

Doctor / Prescriber's Last Name  Doctor / Prescriber's First Name  Doctor / Prescriber's Telephone # --

**COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED**

**Allergies:**  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfonamides/Sulfa  
 None  Other:

**Health Conditions:**  Arthritis  Asthma  Diabetes  GERD (Acid Reflux)  Glaucoma  Heart Condition  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Disorders  Thyroid  
 Other:

---

**#2:**  Easy open caps  Print materials in Spanish

Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth: --

E-mail Address:  Date new prescription(s) received from doctor:

Doctor / Prescriber's Last Name  Doctor / Prescriber's First Name  Doctor / Prescriber's Telephone # --

**COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED**

**Allergies:**  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfonamides/Sulfa  
 None  Other:

**Health Conditions:**  Arthritis  Asthma  Diabetes  GERD (Acid Reflux)  Glaucoma  Heart Condition  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Disorders  Thyroid  
 Other:

Comments/Special Instructions:

---

**Method of Payment/Shipping Information**

Please make check or money order payable to **Caremark**. Include ID# on check/money order.

Check  Money Order/Cashier's Check  Voucher/Coupon **Amt. of check/money order:** \$

(Checks returned for insufficient funds will be subject to a processing fee of up to \$40, depending on state law.)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.

**Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.**

**Fill in oval to charge most recently used credit card for this order only.**

To add, change or update your credit card information, write in below:

- -

Credit/Debit Card Number Expiration Date

Credit Card Holder Signature  Date

Your credit card will be billed for prescription costs and expedited shipping (if requested).


By submitting this form you acknowledge that eligibility under the prescription benefit is subject to plan verification and that you/your dependents do not have primary prescription coverage under any other plan.

**Regular delivery is FREE** (allow up to 10 days for delivery).  
For faster delivery, mark the appropriate oval below.  
Note: Expedited delivery only affects shipping time, not processing time of your order.

**Fill in oval for faster delivery:**

2nd Business Day = \$13 (per order)  Next Business Day = \$18 (per order)

(Charges subject to change.)



TUFTS-COM-1007

Figure 2-6: Caremark® Mail Order Service Form (page 2)

14423-0206

## Prescription Reimbursement Standard Claim Form

**Important!**   \* Always allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.  
\* Make a copy of all documents submitted and do not staple or tape receipts or attachments to this form. No documents will be returned.

### 1 Primary Member/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

#### Primary Member Information

Identification Number (refer to your prescription card) \_\_\_\_\_ Group No./Group Name \_\_\_\_\_  
 Name (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (MI) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### Patient Information—Use a separate claim form for each patient.

ID No. and Patient Codes will be found on your prescription card.  
 Name (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (MI) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Male  Female   
 Relationship to Primary member: Member  Spouse  Child  Other \_\_\_\_\_ Full-Time College Student: Yes  No

**Important! A signature is REQUIRED in both A and B.**

**Fraud Prevention Regulation:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**A**  \_\_\_\_\_  
 Signature of Plan Participant \_\_\_\_\_ Date \_\_\_\_\_

**Release of Information:** I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to Caremark, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

**B**  \_\_\_\_\_  
 Signature of Plan Participant \_\_\_\_\_ Date \_\_\_\_\_

### 2 Prescription Claim Information

NOTE: If you are including all original receipts with the following information, it is not necessary to complete this section. Exception: If submitting compound receipts, this section must be completed. ONLY INCLUDE charges for prescription medications, original receipts and full itemized statements.

<b>Rx</b>	Rx #	Date Filled (m/d/y)	Prescriber's DEA No.	<input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound	For office use only Prior Approval Code
	NDC #	Drug Name and Strength	Metric Quantity	Days Supply	Total Charges

(Over)

Figure 2-7: Caremark® Prescription Reimbursement Standard Claim Form

## 3 Dependent Eligibility

The following section presents Tufts Health Plan's policies for covering dependents.<sup>8</sup> The term "dependent" includes the subscriber's spouse, divorced spouse (when required by law) domestic partner, "child", or disabled dependent.<sup>9</sup> The events that qualify these dependents for enrollment are detailed below.

### Dependent Certification Policy

The Patient Protection and Affordable Care Act (also known as Federal Health Care Reform) provides coverage for adult dependent children until the age of 26. This law is effective for plan years on and after September 23, 2010.

Prior to the effective date of Federal Health Care Reform, dependents currently not covered under group health plan coverage; eligibility for coverage is based on state law. For dependents currently covered under group health plan coverage, Tufts Health Plan will extend eligibility for coverage uninterrupted until the age of 26.

Tufts Health Plan provides coverage for a "child" for two years after the "child" loses federal tax dependent status under the IRS Code, or the age of 26, whichever occurs first. By completing and signing a [Dependent Certification Form](#), subscribers certify the filing year in which the dependent last qualified as a dependent as defined under the IRS Code (Tufts Health Plan will certify annually thereafter). As long as a dependent is qualified as a dependent, they are eligible for coverage until the age of 26(26th birthday).

The first year that the dependent is not qualified, the two-year window of eligibility will begin. The dependent will be eligible for coverage under the family plan until the two-year window is up or until the dependent reaches age 26 (26th birthday), whichever occurs first.

Tufts Health Plan periodically audits dependent certification records and may take any steps it feels necessary to verify the accuracy of the information provided. If we find any misrepresentation, we may terminate the dependent or the family coverage as provided in the subscriber's benefit document, and seek any other available legal remedies.

Unless otherwise agreed to by Tufts Health Plan, a dependent's coverage terminates under the following circumstances:

- Two years from the date the dependent was last qualified as a dependent as defined under the IRS Code (coverage will end on December 31 of the second year), or
- On his/her 26th birthday (whichever occurs first)

---

<sup>8</sup> This is in compliance with MA law and is our standard unless otherwise agreed to by Tufts Health Plan.

<sup>9</sup> Domestic partner coverage can differ by employer group.

- When the subscriber's coverage terminates
- Dependents are recertified once a year in the Fall

## Adopted Child Policy

Coverage for an adopted child is the same as coverage for a natural child, assuming the adopted child meets the Tufts Health Plan definition of an adopted child. Tufts Health Plan's definition of an adopted child can be found in the benefit document.

## Disabled Dependent Policy

Tufts Health Plan covers a disabled natural child, stepchild, or adopted child of the subscriber or spouse, if the dependent meets the definition of disabled dependent in the benefit document.

## Enrollment Process

- Disabled children are covered as dependents until the age of 21.
- Upon turning 21, if a dependent applies for disabled dependent status, the subscriber must complete the two-part Disabled Dependent Form. On the first part of the form, the subscriber certifies that the dependent qualifies as a dependent under the IRS Code. The dependent may be an eligible dependent under Massachusetts law.
- Tufts Health Plan will reverify IRS dependent status annually.
- If the status as an IRS dependent changes before the age of 26 or upon the 26<sup>th</sup> birthday, the application will then be reviewed for disabled dependent status.

Members may contact Member Services for more information regarding enrolling a disabled dependent. To continue coverage for a disabled dependent, the subscriber should contact Member Services approximately 30 days before the dependent's loss of dependent status.

## Domestic Partners Policy

Tufts Health Plan provides domestic partner coverage to employer groups who choose to offer this option to their employees. This section explains the enrollment and eligibility guidelines pertaining to domestic partner coverage. (It is the employer's responsibility to obtain, secure, and maintain documentation of eligible domestic partner participants.)

## Eligibility

This coverage applies to partners of the same sex and the opposite sex, if the following conditions are met:

- The partner must be at least 18 years of age.
- The partner and the employee must not be married and have not been married for at least 12 consecutive months to anyone, cannot be related by blood, and must share a mutually exclusive and enduring relationship.
- The partner and the employee must have shared a common residence for at least 12 consecutive months and intend to do so indefinitely.
- The partner and the employee consider themselves life partners and share joint responsibility for their common welfare, and are financially interdependent.

- Parents, siblings, and roommates are ineligible.
- If an employee changes partners, the new partner is eligible only after the former partner has relocated from the employee's residence for a period of at least 12 months. The new partner must also meet the requirements stated above.
- The employee can only have one domestic partner at a time.
- The employee must be an active employee.

## Dependent Children

Eligibility for dependent children of a domestic partner is the same as eligibility for an employee's stepchildren. The dependent children must reside in the home with the employee and the domestic partner, and the domestic partner must also be enrolled.

## Enrollment/Disenrollment

Enrollment of new hires with domestic partners is the same as for all other employees. Termination procedures are also the same. The employee completes a statement of enrollment or disenrollment.

The employer's Summary Plan Description must contain a statement regarding the employee's responsibility to notify the employer when the employee-partner relationship changes or when any other change occurs that affects the eligibility of the domestic partner.

## Continuation of Coverage for Domestic Partners

Domestic partners are not entitled to COBRA coverage under federal law. However, Tufts Health Plan offers COBRA-like coverage which is identical to COBRA coverage offered to spouses.

COBRA-like coverage is not available at the termination of the domestic partner relationship. COBRA-like coverage is only available to domestic partners or their dependents for those groups with domestic partner coverage for actively-at-work employees.

If a group does not offer domestic partner coverage for actively-at-work employees, Tufts Health Plan offers them the opportunity to enroll in Tufts Health Plan under an individual policy.

## Other Conditions

In addition to the above eligibility and enrollment policies, Tufts Health Plan has the following requirements regarding domestic partner coverage:

- All of the group's carriers must agree to offer coverage to domestic partners on the same basis they extend coverage to spouses.
- The employer contributions must be the same for domestic partners as they are for spouses.

## Michelle's Law

Dependents may qualify as being eligible for group health plan coverage under Michelle's Law. Michelle's Law provides for continued health plan coverage for a student dependent who experiences a medically necessary leave of absence and would otherwise no longer be eligible for coverage. Please contact your Account Manager if you have questions related to Michelle's Law.

## Changing the Type of Coverage

Members can change from individual to family coverage or add dependents by notifying their employer within 30 days of the occurrence of the following events:

- Marriage or remarriage
- Loss of other health insurance that covered the subscriber or dependents
- **Note:** A letter is required from the former employer or insurance carrier.
- Birth or adoption of a child
- Section 125 (“Cafeteria Plan”) qualifying event
- Qualifying event under HIPAA Special Enrollment
- Court decree requiring dependent health coverage

An employee can elect to change from family to individual coverage at any time.

The effective date of this change cannot be more than 60 days from the receipt of the change request. Terminated dependents can be reinstated only when a qualifying event occurs.

To change the employee’s coverage, you and your employee must appropriately complete a Member Enrollment Form or Member Change Form. Incomplete or inappropriately completed forms delay the enrollment process.

## Qualifying Events for Adding Dependents

The following events qualify the employee to add dependents to their health care coverage. Complete the following information on the Member Enrollment Form and supply the appropriate documentation within 60 days of the effective date to initiate the enrollment process.

Event	Necessary Documents
Open Enrollment	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> <li>• Completed Member Change Form</li> </ul>
Marriage and Add Domestic Partner	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul>
Loss of Coverage	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul>
Move into Service Area	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul>
Mandated by Court Decree requiring dependent health care coverage	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul> AND, UPON REQUEST, <ul style="list-style-type: none"> <li>• Legal documentation mandating the subscriber to cover the dependent</li> </ul>
Adoption	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul> AND, UPON REQUEST, <ul style="list-style-type: none"> <li>• Legal documentation indicating when the child was placed with the subscriber for the purpose of adoption.</li> </ul>

Event	Necessary Documents
Birth	<ul style="list-style-type: none"> <li>• Plan upgrade - signed and completed Member Enrollment Form</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• No plan upgrade - no written documentation is required for most groups member can simply call Member Services to add newborn.</li> </ul>
Reinstatement of Dependent	<ul style="list-style-type: none"> <li>• Signed and completed Member Enrollment Form</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>• Dependent Certification form completed by the subscriber</li> </ul>
Qualifying Events under HIPAA/Section 125 Special Enrollment	<ul style="list-style-type: none"> <li>• Contact your account manager with any questions</li> </ul>



## 4 Continuation of Coverage

### COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a 1985 federal law that requires companies with 20 or more employees to offer continuation of coverage to employees and their enrolled dependents who lose their employer-sponsored coverage ("qualified beneficiaries").

If you have questions regarding COBRA regulations, call the Employee Benefits Security Administration in Washington, DC (866-444-3272) and select the COBRA information message.

### COBRA Policies

The following are Tufts Health Plan's policies regarding COBRA:

- Following termination<sup>10</sup> or reduction in work hours, the enrolled employee and eligible dependents become eligible for COBRA beginning on the first day following termination of group health benefits.
- A group member can change his or her COBRA election during a group's open enrollment period. Therefore, someone with prior COBRA, but no affiliation to Tufts Health Plan, can elect COBRA coverage with Tufts Health Plan on the open enrollment date.
- Dependents who are eligible for COBRA because they lost dependent status (e.g., aged out) cannot be put on COBRA within their former family membership. They would be eligible as an individual and must submit a Member Enrollment Form.

### Length of Eligibility

The length of time an individual is eligible for COBRA depends on the reason for termination from the Plan and can vary from 18 to 36 months<sup>11</sup>.

**Note:** Tufts Health Plan only allows for continuation of coverage for the minimum period required by law.

### COBRA Administrative Steps

In addition to the administration and notification provisions required by COBRA, Tufts Health Plan requires you to do the following with respect to continuation of coverage:

---

<sup>10</sup> Except for gross misconduct.

<sup>11</sup> If members are disabled within 60 days of the COBRA qualifying event due to the loss of employment or reduction in hours, they may be eligible for 11 extra months of COBRA coverage for a total of 29 months.

## Termination from Medical Coverage

When an employee or dependent becomes ineligible for group coverage, complete and submit a Member Change Form with the reason code that appropriately indicates the reason for termination.

## Reinstatement

To reinstate a member due to COBRA election, you must complete a Member Change Form listing the subscriber's social security number and name, plan code, effective date, and reason code 108.

## Termination from COBRA

To terminate a member from COBRA, complete a Member Change Form listing the subscriber's social security number and name, plan code, effective date, and reason code 366.

## Notice Requirements

When a member seeks conversion to COBRA coverage, the following conditions apply:

- Member must notify you within 60 days of COBRA notification that they elect to continue coverage through COBRA
- Member must send the first premium check to you within 45 days after signing the Member Enrollment Form or COBRA election form
- You must notify Tufts Health Plan of the member's decision to elect COBRA.

When an employee's dependent elects individual COBRA continuance, the dependent must complete a Member Enrollment Form. You must attach this form to a completed Member Change Form and submit it to Tufts Health Plan's Enrollment department.

## Individual Coverage

When a member's coverage under federal of coverage ends, the member and the member's enrolled dependents may be entitled to apply for individual coverage.

The member may call a Tufts Health Plan member services specialist at 866-352-9114 for more information.

## 5 Premium Billing

Your Tufts Health Plan billing invoices are sent approximately 21 days in advance of the payment due date. For example, in January you will receive the February invoice.

Payment in full is due on or before the date set forth in your Employer Group Agreement with Tufts Health Plan. Most commonly, this is the first of the month. Any premium received after that date is considered delinquent and could result in termination of coverage.

We appreciate your prompt payment of invoices so that service to your employees is not disrupted.

### Premium Billing Invoices

Premium billing invoices are available both through the mail and online. Online billing allows you to review and update your billing information on Tufts Health Plan's secure Web site. Contact your account manager for additional information about registering for this service.

### Online Billing

Tufts Health Plan's online billing program enables you to manage your Plan's administration online. Using this program you can:

- Make online adjustments to enrollment data by adding or terminating a subscriber and changing demographic information
- View online payment activity
- Make payments from checking or savings accounts
- Set up one-time payment accounts
- Establish separate payment accounts
- Print a remittance stub and mail payment to Tufts Health Plan
- Receive email notifications when:
  - A preview invoice is available online (approximately ten calendar days prior to billing cut-off date)
  - A final invoice is available online
  - You make payment transactions
  - Your payment transactions are not successful

## Premium Billing Policies

Tufts Health Plan does not prorate monthly group premium payments. Member charges for additions, terminations, and plan changes are based on the effective date of the change. Members are charged either the full month's premium or no premium for the month based on the effective date of change.

### Additions to the Plan

Tufts Health Plan bills a full month's premium for each subscriber who is effective on or before the 15<sup>th</sup> day of the monthly billing cycle. Tufts Health Plan does not bill that month's premium for subscribers who are effective after the 15<sup>th</sup> day of the monthly billing cycle.

### Terminations from the Plan

Tufts Health Plan bills a full month's premium for each subscriber who terminates after the 15<sup>th</sup> day of the monthly billing cycle. Tufts Health Plan does not bill that month's premium for subscribers who terminate on or before the 15<sup>th</sup> day of the monthly billing cycle.

## Remittance

To ensure faster and more accurate posting of payment to your account, you must remit a check together with the returnable coupon in the return envelope enclosed with your invoice.

### Wire Payment

Tufts Health Plan offers two electronic options for your premiums. You can send all Automatic Clearing House (ACH) or WIRE payments to Bank of America at the respective address below, depending on the method of payment chosen:

<b>ACH</b>	<b>WIRE</b>
Tufts Health Plan	Tufts Health Plan
P.O. Box 9224	P.O. Box 9224
Chelsea, MA 02150-9224	Chelsea, MA 02150-9224
ABA #011000138	ABA # 026009593
Account # 44850672	Account # 44850672

To ensure accurate distribution of your payment, we encourage you to use CCD+ format for electronic payments by including your company's name and eight digit Tufts Health Plan group number. For further information, contact your Account Manager.

### Online Payment

Remittance may be paid online from your checking or savings account. Payments can be set up at your convenience as either one-time or recurring payments. You can view all Web payment activity online and select to receive e-mail notifications of payment transactions. Contact your account manager for additional information about registering for this service.

## Correspondence

Remittance can be submitted through the mail. To ensure faster and more accurate posting of payment to your account, you must remit a check and the returnable coupon in the return envelope enclosed with your invoice.

All other enrollment and premium billing correspondence must be sent to:

Tufts Health Plan  
Commercial Enrollment/Eligibility  
PO Box 9186  
Watertown, MA 02471-9186

## Reading the Premium Bill

This section explains the premium bill, or invoice, that Tufts Health Plan sends to your group to collect monthly premium. The first part of the bill is a two-sided invoice. Attached to the invoice is a list of subscribers and their subscriber numbers, plan types, and individual premium amounts.

## Statement of Account and Returnable Coupon

At the top of the first page, the Statement of Account displays your group's current-month balance and any outstanding invoice balances. The Period Covered column defines the period to which the balance applies.

At the bottom of the first page is the returnable coupon that must be returned with your payment to ensure that Tufts Health Plan applies the payment accurately.

A check box for indicating an address or contact name change is on the coupon. If your company changes its location or its contact for Tufts Health Plan's Enrollment and Premium Billing department, mark the check box and write the new information on the reverse side.

## Explanation of Invoice

The back side of the first page is the Explanation of Invoice, which contains a key to transaction types, addresses for mailing enrollment documents, toll-free and fax numbers, a box for new address or contact information, and, when needed, updates regarding billing for Tufts Health Plan.

## Transaction Types

This section lists enrollment and billing transaction codes and their meanings. Examples of codes are TE (member termination) and RC (rate change). The transaction codes for your group appear on the Adjustment Detail, the last page of the bill.

## Important Updates

To the right of the transaction codes is an area where important updates appear. Check this area for information on changes implemented by the Enrollment and Premium Billing departments or for other helpful information regarding your invoice and Tufts Health Plan.

## Toll-Free and Fax Numbers

These are the numbers commonly used to reach Tufts Health Plan’s Member Services and Enrollment and Premium Billing departments. This page also lists the company’s Web site address [www.tuftshealthplan.com](http://www.tuftshealthplan.com), where you can learn more about Tufts Health Plan.

## Details of Premium Bill

The following pages display a sample employer-group bill. The table below describes each section of the bill. The reference numbers correspond to the same numbers shown in the boxes on the sample bill. A sample invoice is provided on the following pages. Please note that this is a sample only and some funding costs or categories may not be applicable for all products. Contact your Account Manager for more information.

Reference Number	Refers to this Section of the Bill
1	Your group’s name, contact, and address
2	Tufts Health Plan’s address to send payment
3	Statement of Account - the summary of what your group currently owes Tufts Health Plan
4	Toll-free number to call with any questions regarding the bill
5	Date through which Tufts Health Plan has processed enrollment and payment
6	Tear-off remittance coupon
7	Check box to indicate address or contact-name change
8	Total amount owed to Tufts Health Plan, which is equal to all outstanding balances, including current period and balances remaining from prior invoices.
9	Amount owed for the current month
10	Date payment is due at Tufts Health Plan
11	Invoice number
12	Period the invoice covers
13	Your Tufts Health Plan group number
14	Codes for transaction types (see the last page of the invoice)
15	Free text section where Tufts Health Plan displays important updates
16	Addresses to which you can mail forms (this address differs from the address to which you send payments)
17	Commonly used Tufts Health Plan phone numbers
18	Commonly used Tufts Health Plan fax numbers
19	Section for indicating your group’s change of contact or address

Reference Number	Refers to this Section of the Bill
20	Employee's contract number, social security number, or Tufts Health Plan unique ID number
21	Employee's name
22	Code for the plan type in which the subscriber is enrolled
23	Subscriber's monthly premium
24	Total number of plan types for all subscribers in the group, minus those for whom adjustments have been made (adjustments are listed on the last page)
25	The Adjustment Detail - Lists all transactions (adjustments) made to a group during the past month, e.g., subscribers who have been added or terminated
26	Transaction Type - The type of adjustment made for the member during the month
27	Time period in which adjustment falls
28	Credit - Credit applied to the group's account, usually caused by a member's termination
29	Debit - Debit owed by the group, usually caused by the addition of a member
30	Subtotal - The final debit or credit for each subscriber The Adjustment Subtotals lists the total monthly debit or credit for the group's adjusted subscribers

Group Number	00999-000
Due Date	AUG 1, 2008
Invoice Number	000000002461278
Period Covered	AUG 1, 2008 TO AUG31,2008
Invoice Date	JUL 15, 2008

1 → GROUP NAME  
 CONTACT NAME  
 STREET ADDRESS  
 TOWN, STATE, ZIP CODE

2 → Payment Address:  
**Tufts Health Plan**  
**PO Box 9224**  
**Chelsea, MA 02150-9224**

**Statement of Account:**

3 → **Current Invoice**


Previous Amount Due	\$118,877.05
Payments Received After 08/07/2008	(\$81,871.05)
Cash Adjustments After 08/07/2008	\$0.00
08/01/2008-08/31/2008	83,532.67

**TOTAL AMOUNT DUE** \$120,538.67

**PLEASE PAY TOTAL AMOUNT DUE**  
 IF THERE ARE ANY QUESTIONS REGARDING PREMIUM PAYMENTS OR ENROLLMENT, CALL THE  
 ENROLLMENT & PREMIUM BILLING DEPARTMENT AT (800) 818-4388

*Invoice Includes Enrollment and Payment Activity Processed Through 07/15/2008*  
 Please detach and remit payment, keep top portion for your records

---

**TUFTS  Health Plan**

Address or contact name change? Please mark box and see reverse side.

No one does more to keep you healthy.

Total Amount Due	Current Invoice Amount	Due Date	Invoice Number	Period Covered		Group Number
				From	To	
\$120,538.67	\$83,532.67	08/01/2008	000000002461278	08/01/2008	08/31/2008	00999-000

GROUP NAME  
 CONTACT NAME  
 STREET ADDRESS  
 TOWN, STATE, ZIP CODE

Please mail this portion with your check to:  
**Tufts Health Plan**  
**PO Box 9224**  
**Chelsea, MA 02150-9224**

009990000000000000246127871000030087001205386700063532672

Figure 5-1: Front Page of the Premium Bill

**Explanation of Invoice**

**Total Amount Due** is equal to all outstanding balances including current period and balances remaining from prior invoices.

**Due Date** is the date the invoice payment is due.

**Credits:** Indicated by dollar figure(s) in parenthesis.

**Transaction Types**

AD = Member Addition  
TE = Member Termination  
PC = Plan Change  
RC = Rate Change

**Please mail all enrollment documents to:**  
Enrollment & Premium Billing  
PO Box 9186  
Watertown, MA 02471-9186

CONNECT WITH YOUR HEALTH PLAN BENEFITS  
HEALTH AND WELLNESS. MEMBER REWARDS  
SELF-SERVICE TOOLS AT YOUR FINGERTIPS  
VISIT US AT [WWW.TUFTSHEALTHPLAN.COM](http://WWW.TUFTSHEALTHPLAN.COM)

**Toll Free Numbers**

ENROLLMENT & BILLING QUEUE LINE: 1-800-810-1388  
MEMBER SERVICES: 1-800-462-0224  
EMPLOYER WEB QUEUE 1-866-300-1712

**Fax Numbers**

ENROLLMENT & BILLING 1-617-923-5998

To learn more about Tufts Health Plan, please visit our web site at: [www.tuftshealthplan.com](http://www.tuftshealthplan.com)

Name \_\_\_\_\_  
Address 1 \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Contact Name \_\_\_\_\_  
*(if different than name)*

**Figure 5-2:** Explanation of Invoice (Page 2 of Premium Bill)





## Reminder and Termination Letters

Premium reminder letters are sent to groups within five business days of the invoice due date if payment has not been posted. A reminder letter is the first notification of an overdue payment.

If payment is not immediately received, a termination letter is mailed to the group indicating the date of termination. A group can be reinstated for non-payment only once. If a group is terminated a second time for non-payment, it will not be reinstated.

To comply with Massachusetts state regulations, all subscribers are notified in writing of the termination for non-payment of premium. Under Massachusetts Office of the Attorney General Regulations at 940 CMR 9.00 Group Health Care Insurers, Termination of Coverage, all insurers, including Tufts Health Plan, are required to notify all subscribers listed under a group's plan of a termination of benefits due to a group's non-payment. Under these regulations, this notice must include: a) the date of termination of benefits; b) that the termination was a result of the group's non-payment; c) that the benefits are covered only to the date of termination; and d) that temporary continuation of coverage is available from the date of termination through the date of notice.

## 6 Member Information

Tufts Health Plan sends materials to employees and their dependents when they become Tufts Health Plan members. This section outlines these materials and the process the employees must follow if they have issues or concerns about a claim or quality of care.

### Member Materials

Subscribers are furnished with the following materials once they join Tufts Health Plan:

- Tufts Health Plan membership ID card (one for each member)
- Benefit document
- Online member benefits
- CareLink provider directory (available on request)<sup>12</sup>
- Caremark<sup>®</sup> Mail Service Order Form (available on request)<sup>12</sup>

### Membership ID Card

A valid Tufts Health Plan ID card identifies the named person as a Tufts Health Plan member. The member must use this card for provider office visits, medical emergencies, prescription drug coverage, and access to many of the wellness and fitness benefits.

### Benefit Document

The benefit document provides members with detailed information about their medical coverage and is the member's contract with Tufts Health Plan.

---

<sup>12</sup> Members can call Member Services at 866-352-9114 to request this information.

## Online Member Benefits

Members can view their current coverage information on the secure Member Resource Center on Tufts Health Plan's Web site. Using this online resource, members can also access more detailed, up-to-date personal benefit. Members can:

- View plan deductibles, if applicable, as well as amounts accumulated toward deductibles
- Check copayment and coinsurance amounts for health care visits and other services
- View the status of claims
- Confirm any out-of-pocket maximum and how much has been paid toward it
- Review how much of a particular benefit has been used to date
- View in- and out-of-network benefits, if applicable, and print copies

## CareLink Provider Directory

The directory lists CareLink contracting providers and other medical providers according to the city or town in which they practice. It also includes their hospital affiliation and whether they are primary care providers (PCP) or specialists. This information is also available on [www.tuftshealthplan.com](http://www.tuftshealthplan.com).

## Caremark<sup>®</sup> Mail Service Order Form

Members use this form to order up to a 90-day supply of maintenance medication through the mail at one time. The mail order service provides members the opportunity to save money on maintenance medications (benefits vary). Most Tufts Health Plan members pay only two times the 30-day retail copayment and can receive up to a 90-day supply.

If you want any of the printed material listed above, ask your Tufts Health Plan account representative. It is also available on [www.tuftshealthplan.com](http://www.tuftshealthplan.com).

## Massachusetts 1099-HC Form Information

The MA 1099-HC form serves as proof of health insurance coverage for Massachusetts residents age 18 and over. The Commonwealth of Massachusetts requires this form for state income tax filing. The form will indicate the previous calendar year's coverage through Tufts Health Plan. Tufts Health Plan will send this form annually, (by January 31st) to Massachusetts subscribers.

The MA 1099-HC form is also available on the member secure site at [www.tuftshealthplan.com](http://www.tuftshealthplan.com), or upon request through our Member Services Department.

## Member Satisfaction

Tufts Health Plan makes every attempt to resolve member issues regarding claims or quality of care. When a member is dissatisfied with a service, he or she must notify a Tufts Health Plan member services specialist. The member services specialist assists the member in determining which member satisfaction process is appropriate. Tufts Health Plan has two processes to resolve member issues.

## Appeals Process

The appeals process provides for review by Tufts Health Plan and, in the case of medical necessity determinations, for independent external review. The process is described in the benefit document, as well as

in the letters that are sent to members during the process. There is also an expedited review process that is used when the member's condition requires it.

## Grievance Process

The grievance process provides for review by Tufts Health Plan if members have concerns about quality of care or administrative issues.

## Additional Information

If you want additional information, contact your account representative at the appropriate telephone number (see [Chapter 1, Introduction](#)), a Tufts Health Plan member services specialist at 866-352-9114, or visit Tufts Health Plan's Web site ([www.tuftshealthplan.com](http://www.tuftshealthplan.com)).

## Reminder and Termination Letters

Premium reminder letters are sent to groups within five business days of the invoice due date if payment has not been posted. A reminder letter is the first notification of an overdue payment.

If payment is not immediately received, a termination letter is mailed to the group indicating the date of termination. A group can be reinstated for non-payment only once. If a group is terminated a second time for non-payment, it will not be reinstated.

To comply with Massachusetts state regulations, all subscribers are notified in writing of the termination for non-payment of premium. Under Massachusetts Office of the Attorney General Regulations at 940 CMR 9.00 Group Health Care Insurers, Termination of Coverage, all insurers, including Tufts Health Plan, are required to notify all subscribers listed under a group's plan of a termination of benefits due to a group's non-payment. Under these regulations, this notice must include: a) the date of termination of benefits; b) that the termination was a result of the group's non-payment; c) that the benefits are covered only to the date of termination; and d) that temporary continuation of coverage is available from the date of termination through the date of notice.

