Employer Group PPO Fully-Insured Manual

Massachusetts

January 2024

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1 Introduction

Welcome to the *Tufts Health Plan Preferred Provider Option 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 Canton, MA
- (800) 208-8013 Canton, MA

About Tufts Health Plan and the PPO Fully-Insured Product

PPO members are strongly encouraged to (although not required to) select a primary care provider (PCP) from our network of contracting providers. This PCP can provide or arrange for all care for the member, with the goal of providing the member with the most appropriate treatment.

The PPO 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 Tufts Health Plan network. The out-of-network level of benefits applies when a member chooses to receive care from providers who are not part of the Tufts Health provider network.

Our member service specialists can help a member choose a PCP. Specialists are available at 800-462-0224. A member can also choose a PCP from our Directory of Healthcare Providers, or by accessing our Web site at tuftshealthplan.com.

Changing the Member's Primary Care Provider

When a member wants to change his or her PCP, he or she can visit the Web site or call a Tufts Health Plan member services specialist at 800-462-0224 to notify the Plan of the change. The member services specialist verifies that the PCP is accepting new patients and makes the appropriate change to the member's record.

Level of Benefits

Tufts Health Plan members can obtain health care from: 1) a provider within the Tufts Health Plan national 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 Tufts Health Plan provider network (physicians, hospitals, and other providers), the member is responsible for paying any applicable deductible, copayment, and/or coinsurance for services.

If a Tufts Health Plan member requires inpatient mental health or inpatient substance abuse services, he/she can go to any provider network facility and receive coverage at the in-network level of benefits[1].

Out-of-Network Level of Benefits

If a member chooses to receive care from providers who are not part of the Tufts Health Plan national 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. The PPO 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 Tufts Health Plan network. The out-of-network level of benefits applies when a member chooses to receive care from providers who are not part of the Tufts Health Plan provider network. Our member service specialists can help a member choose a PCP. Specialists are available at 800-462-0224. A member can also choose a PCP from our Directory of Healthcare Providers, or by accessing our Web site, tuftshealthplan.com

Emergency Medical Coverage

Tufts Health Plan members are always covered for an emergency at the In-Network/Authorized level of benefits, no matter where they are or what time it is. Please see the benefit document for a description of an emergency.

1 A deductible may apply.

2 Administering Your Plan

This section provides information on provider access enrollment areas, enrollments, qualifying events, and forms. See the *Summary of Forms* for sample forms and related information.

Tufts Health Plan's Provider Access Area

The provider access area includes:

- All of Massachusetts
- All of Rhode Island
- All of New Hampshire
- Towns in Connecticut, Maine, New York, and Vermont where contracted primary care providers (PCP) are located

Enrollments

Eligible employees and dependents can enroll in Tufts Health Plan within 30 days of their eligibility effective date, if they live, work, or reside within the Tufts Health Plan enrollment service area[1].

Divorced spouses who are required to be covered under state law and members eligible for COBRA/MA (MA COC) Massachusetts are eligible for PPO under the same guidelines as active employees.

Web Enrollment

Tufts Health Plan's web enrollment and roster capabilities 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

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)

1 POS OOA only members are eligible for the authorized level of benefits for emergency and urgent care services only. Any non-emergent services are limited to the unauthorized level of benefits.

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.

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[2] occur, employees qualify to enroll in Tufts Health Plan and must send the appropriate documents or similar electronic transaction 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.	• Signed and completed *Member Enrollment Form*
New Hire	A new employee who meets the employer's qualifications for health benefits.	• Signed and completed *Member Enrollment Form*
Rehire	An employee who is rehired and meets the employer's qualifications for health benefits.	Less than 60-day gap between the termination and rehire date: • Completed *Member Change Form* only Greater than 60-day gap between the termination and rehire date: **NOTE:** Member could have to resatisfy a waiting period, if one exists. • Signed and completed *Member Enrollment Form*
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.	• Signed and completed *Member Enrollment Form* OR • Completed *Member Change Form*

2 Qualifying events for dependents are reviewed in *Chapter 3, Dependent Eligibility*.

Qualifying Event	Description	Necessary Documents
HIPAA or Section 125 Special Enrollment	Subscriber experiences a HIPAA/Section 125 qualifying event.	• Signed and completed *Member Enrollment Form*
Loss of Coverage	Employee has lost coverage with previous insurance company.	• Signed and completed *Member Enrollment Form*
Move	Employee moves into or out of Tufts Health Plan's 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 *Chapter 3, Dependent Eligibility*).	• Signed and completed *Member Enrollment Form*
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.	• Signed and completed *Member Enrollment Form*

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[3]:

- 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 or send a similar electronic transaction 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

3 Only applies to employers offering more than one product.

Terminations

Employers are responsible to notify their employees of prospective discontinuances of coverage upon the employees termination of employment (or other applicable eligibility reason). Tufts Health Plan receives the termination from the employer and follows an agreed upon administrative process, as described below, to affect the termination. Our understanding is that such cancellation or discontinuance of coverage prospectively is allowed under federal Health Care Reform and is not considered a recision.

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 and Premium Billing department receives the termination request. To process a termination, Tufts Health Plan must receive a *Member Change Form* or similar electronic transaction within 60 days of the coverage end date. Coverage is continued until midnight of the termination date requested.

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.

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[4] 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.

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.

4 New additions must experience a valid qualifying event.

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.

Qualifying Event	Description	Necessary Documents
Member Enrollment Form	• Enroll members in plan • Add dependents • Upgrade coverage, e.g., Individual to Family	Member section: • Complete form Employer section: • Enter group number • Enter effective coverage date, type of enrollment and date of employment • Review form for completeness • Sign and date the *Member Enrollment Form* • Submit form to Tufts Health Plan
Member Change Form	• Member name, address or telephone changes • Dependent changes • Reinstatement of membership for COBRA/COC coverage • Downgrade coverage, e.g., Family to Individual • Coverage termination	• Ensure form is complete • Ensure reason code is correct • Send form to Tufts Health Plan
OptumRx® Prescription Reimbursement Form (if your plan provides prescription coverage)	• Request reimbursement for out-of-pocket prescription expenses	• Member completes form • Send form to OptumRx (the address is stated on the claim form)
Member Reimbursement Form	• To file for reimbursement for services provided by a non-Tufts Health Plan provider	Member's responsibility • Ensure that the form is complete • Send the completed form to Tufts Health Plan
OptumRx® Mail-In Order Form (if your plan provides prescription coverage)	• Obtain up to a 90-day supply of maintenance medicine at one time - typically provides copayment savings to members	• Member requests doctor to write a new prescription (up to a 90-day supply, with up to three 90-day refills, if appropriate) • Complete the *Patient Profile/Mail Service Order Form* • Mail the form, the original prescription, and payment to: - OptumRx P.O. Box 2975 Mission, KS 66201 • Prescriptions are delivered 10 to 14 days from the date the order was mailed

Sample Forms

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

WELCOME TO TUFTS HEALTH PLAN

TUFTS Health Plan

Please fill in the "subscriber" sections of this membership application completely so we do not delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon.

Employer Section

Your employer must fill out this section.

Employee Section

- Personal Information: Complete all enrollment information. Please select a primary care provider (PCP). Be sure to fill out this section for all members, including dependents.
- Product Code: Please be sure to fill in the correct product code for the plan you have selected. (Please use chart on the right.)
- **Primary Care Provider: If your plan requires you to choose a PCP, it is important that you select one right away. Until we know who your PCP is, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the Doctor Search feature. On this application, indicate whether you are a current patient of the PCP you have listed. (You are a current patient if you have routinely received health care services from this provider in the past.) If you are selecting a new PCP, contact the provider's office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam.**
- Other Health Coverage: If you have other or additional insurance (such as Medicare), please check the correct box and fill in the requested information. If you do not have any other insurance, be sure to check the "No" box.

When the Application is Complete

- Give the application to your employer.
- Employer mails the form to:
  Tufts Health Plan
  P.O. Box 506
  Canton, MA 02021

Notices

By enrolling, you understand and agree that if you or any of your enrolled dependents obtain a health care benefit or payment that you are not entitled to receive, or if you knowingly present a claim that contains a false statement, you may lose your health care coverage and can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including the cost of the investigation.

Tufts Health Plan arranges for the provision of health care services through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan. Tufts Health Plan does not directly provide health care services.

Product Codes

Write the corresponding letter in the product box in the subscriber section of the enrollment application.

- **A.** HMO Premium
- **B.** HMO Value
- **C.** HMO Basic
- **D.** HMO Choice Copay
- **E.** Advantage HMO
- **F.** Advantage HMO Saver
- **G.** POS
- **H.** POS Choice Copay
- **I.** EPO
- **J.** EPO Choice Copay
- **K.** PPO
- **L.** Advantage PPO
- **M.** Advantage PPO Saver
- **N.** Navigator by Tufts Health Plan
- **O.** CareLink
- **P.** Select HMO
- **Q.** Select Advantage HMO
- **R.** Rhode Island HEALTHPact
- **S.** Your Choice HMO
- **T.** Your Choice PPO
- **U.** Steward Community Choice
- **LPC.** Lifespan Premier Choice

We speak over 200 languages.
Call Member Services.

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiềng Việt
Nou pale Kreyòl
យើង និយាយ ភាសាខ្មែរ

Need Help?

If you need assistance selecting a PCP, visit tuftshealthplan.com and use the Doctor Search feature. If you need help filling out this form, call a Member Services Representative.

Member Services:

800.462.0224

COM-30100003-201810 18079

FIGURE 1: Member Enrollment Form (page 1)

MEMBER ENROLLMENT FORM

FAILURE TO COMPLETE FORM WILL CAUSE A DELAY IN ENROLLMENT.

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 506 • Canton, MA 02021

EMPLOYER SECTION

PLEASE WRITE IN YOUR 8 DIGIT GROUP NUMBER BELOW

Group/Company Name_____ Group Number_____

Office Location_____ Date of Hire_____ Effective Date of Coverage_____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify)_____ Qualifying Event Date_____

SUBSCRIBER SECTION

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

Last Name_____ First Name_____ Middle Initial_____

Employee Social Security Number (required)_____ – _____ – _____ Date of Birth (MM/DD/YYYY)_____ / _____ / _____ Gender: ❑ Male ❑ Female

Residential Address (required) _____ City_____ State_____ ZIP_____

P.O. Box (optional) _____ City_____ State_____ ZIP_____

Email Address _____ Home/Work Telephone (_____) _____ Cell Phone (_____) _____Primary Language_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Family ❑ Other_____

Primary Care Provider First Name_____ Last Name_____ PCP/ NPI # _____ Is this your current PCP? ❑ Yes ❑ No

Members Enrolling First Name / Last Name (if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number (required for all members)	Choose a Primary Care Provider for each member (Include first and last name.)	Check if currently used for primary care	PCP NPI #
❑ Spouse ❑ Domestic Partner			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	
Child/Dependent			– –		❑	

Please check if you are using additional membership applications for additional dependent children. ❑

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? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan_____ Name of Plan Holder_____ Health Plan Number_____ Effective Date_____

Names of Family Members Covered_____ Is Spouse Employed? ❑ Yes ❑ No If Yes, Name and Address of Employer _____

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 payments 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.

Subscriber Signature_____ Date_____ **Employer Signature** (required)_____ Telephone_____ Date_____

FIGURE 1: Member Enrollment Form (page 2)

TUFTS Health Plan

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 506
CANTON, MA 02021
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: Member Change Form

OPTUMRx®

NEW PRESCRIPTION MAIL-IN ORDER FORM

1 Member and physician information — please use black or blue ink. One form per member.

Member ID Number		
(Additional coverage, if applicable) Secondary Member ID Number		
Last Name	First Name	MI
Delivery Address		Apt. #
City	State	ZIP
Phone Number with Area Code		
Date of Birth (mm/dd/yyyy)	Gender ○ M ○ F	Email
Physician Name		
Physician Phone Number with Area Code		

2 Health history

Medication Allergies:	○ Aspirin	○ Erythromycin	○ Quinolones	○ Others:
○ None known	○ Cephalosporins	○ NSAIDs	○ Sulfa	
○ Amoxil/Ampicillin	○ Codeine	○ Penicillin	○ Tetracyclines	
Health Conditions:	○ Asthma	○ Glaucoma	○ High cholesterol	○ Others:
○ None known	○ Cancer	○ Heart condition	○ Osteoporosis	
○ Arthritis	○ Diabetes	○ High blood pressure	○ Thyroid Disease	

Over-the-counter/herbal medications taken regularly:

3 Payment and shipping information — do not send cash

Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

You may log on to **optumrx.com** to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

○ **Ship overnight.** Add $12.50 to order amount (subject to change).
○ **Check enclosed.** All checks must be signed and made payable to: OptumRx.
○ **Charge to my credit card on file.**
○ **Charge to my NEW credit card.**

New Credit Card Number

Expiration Date (Month/Year) ___/___

Visa, MasterCard, AMEX and Discover are accepted.

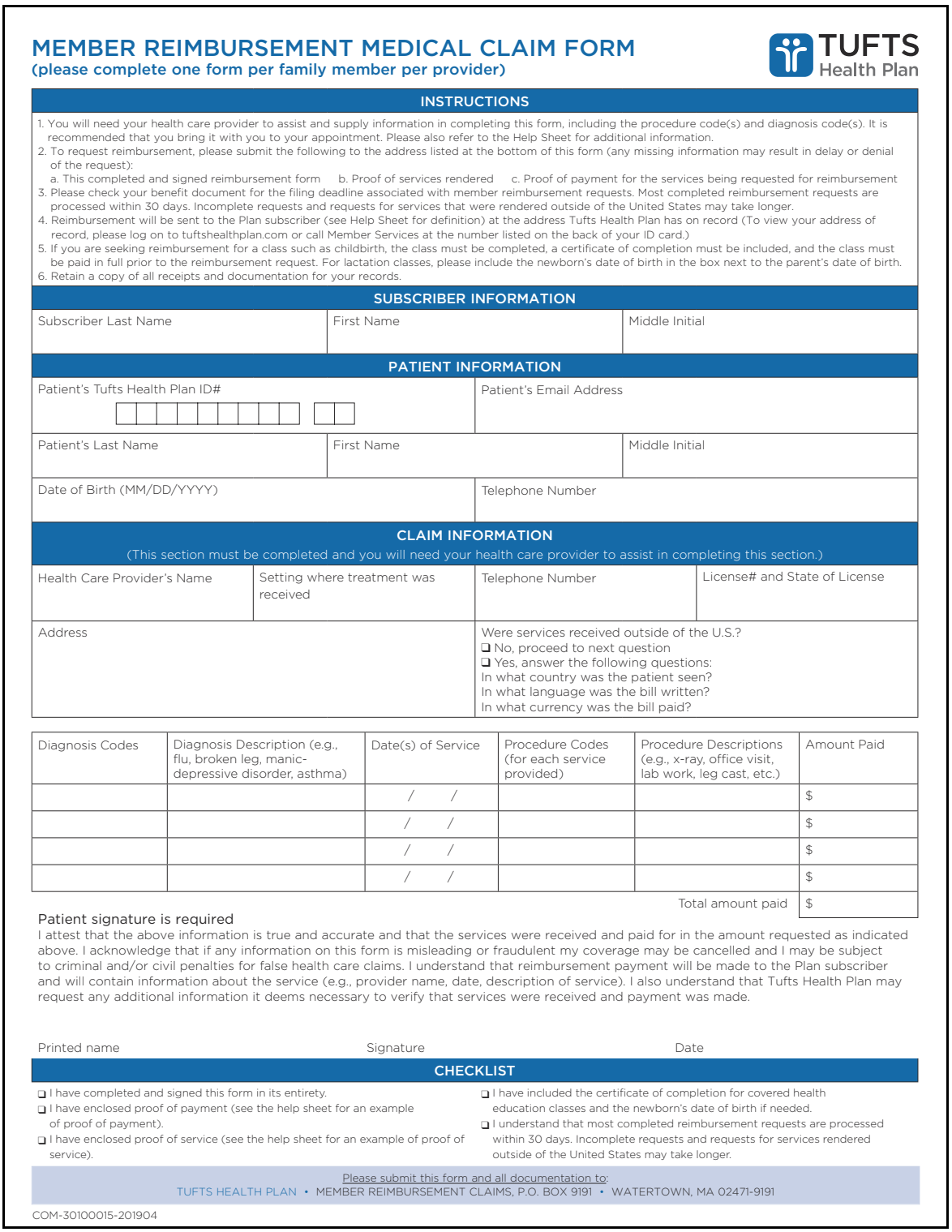
Signature: _____ **Date:** _____

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, **I authorize OptumRx to maintain my credit card on file as payment method for any future charges.** To modify payment selection, contact customer service at any time.

4 Mail this completed order form with your new prescription(s) to OptumRx, P.O. Box 2975, Mission, KS 66201. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

ORX5633E_140915 **NRX001**

FIGURE 3: OptumRx Mail-In Order Form



MEMBER REIMBURSEMENT MEDICAL CLAIM FORM

(please complete one form per family member per provider)

TUFTS Health Plan

INSTRUCTIONS

1. You will need your health care provider to assist and supply information in completing this form, including the procedure code(s) and diagnosis code(s). It is recommended that you bring it with you to your appointment. Please also refer to the Help Sheet for additional information.
2. To request reimbursement, please submit the following to the address listed at the bottom of this form (any missing information may result in delay or denial of the request):
   a. This completed and signed reimbursement form b. Proof of services rendered c. Proof of payment for the services being requested for reimbursement
3. Please check your benefit document for the filing deadline associated with member reimbursement requests. Most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services that were rendered outside of the United States may take longer.
4. Reimbursement will be sent to the Plan subscriber (see Help Sheet for definition) at the address Tufts Health Plan has on record (To view your address of record, please log on to tuftshealthplan.com or call Member Services at the number listed on the back of your ID card.)
5. If you are seeking reimbursement for a class such as childbirth, the class must be completed, a certificate of completion must be included, and the class must be paid in full prior to the reimbursement request. For lactation classes, please include the newborn's date of birth in the box next to the parent's date of birth.
6. Retain a copy of all receipts and documentation for your records.

SUBSCRIBER INFORMATION

Subscriber Last Name	First Name	Middle Initial

PATIENT INFORMATION

Patient's Tufts Health Plan ID#	Patient's Email Address

Patient's Last Name	First Name	Middle Initial

Date of Birth (MM/DD/YYYY)	Telephone Number

CLAIM INFORMATION

(This section must be completed and you will need your health care provider to assist in completing this section.)

Health Care Provider's Name	Setting where treatment was received	Telephone Number	License# and State of License

Address	Were services received outside of the U.S.? ❑ No, proceed to next question ❑ Yes, answer the following questions: In what country was the patient seen? In what language was the bill written? In what currency was the bill paid?

Diagnosis Codes	Diagnosis Description (e.g., flu, broken leg, manic-depressive disorder, asthma)	Date(s) of Service	Procedure Codes (for each service provided)	Procedure Descriptions (e.g., x-ray, office visit, lab work, leg cast, etc.)	Amount Paid
		/ /			$
		/ /			$
		/ /			$
		/ /			$
				Total amount paid	$

Patient signature is required

I attest that the above information is true and accurate and that the services were received and paid for in the amount requested as indicated above. I acknowledge that if any information on this form is misleading or fraudulent my coverage may be cancelled and I may be subject to criminal and/or civil penalties for false health care claims. I understand that reimbursement payment will be made to the Plan subscriber and will contain information about the service (e.g., provider name, date, description of service). I also understand that Tufts Health Plan may request any additional information it deems necessary to verify that services were received and payment was made.

Printed name Signature Date

CHECKLIST

❑ I have completed and signed this form in its entirety.
❑ I have enclosed proof of payment (see the help sheet for an example of proof of payment).
❑ I have enclosed proof of service (see the help sheet for an example of proof of service).
❑ I have included the certificate of completion for covered health education classes and the newborn's date of birth if needed.
❑ I understand that most completed reimbursement requests are processed within 30 days. Incomplete requests and requests for services rendered outside of the United States may take longer.

Please submit this form and all documentation to:
TUFTS HEALTH PLAN • MEMBER REIMBURSEMENT CLAIMS, P.O. BOX 9191 • WATERTOWN, MA 02471-9191

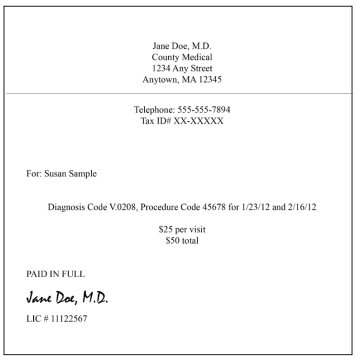
COM-30100015-201904

FIGURE 4: Member Reimbursement Form (page 1)

MEMBER REIMBURSEMENT MEDICAL CLAIM FORM HELP SHEET

FIELD NAME	DESCRIPTION
Subscriber Information	Subscriber is the person: • who enrolls in Tufts Health Plan and signs the membership application form on behalf of him/herself and any dependents. • in whose name the premium is paid.
Patient's Tufts Health Plan ID#	ID# with suffix, found on the front of the Tufts Health Plan ID card.
Patient's Name	Last and First names and Middle Initial of patient who received services.
Patient's Date of Birth	Date of birth: month (2 digits), day (2 digits), year (4 digits). Include newborn's date of birth in the same box as the parent's for lactation classes.
Provider's Name, Address, Telephone Number, License#, and State of License	A provider includes, but is not limited to, hospitals, physicians, optometrists, psychiatrists, licensed clinical social workers, Durable Medical Equipment suppliers, and pharmacies (for covered items that are not submitted to your pharmacy vendor).
In what setting did the patient receive treatment?	Such as office, emergency room, outpatient hospital (for X-rays, tests), inpatient hospital, clinic, medical supply store.
If services were rendered outside of the U.S.	If applicable, indicate in what country services were provided, in what language (if not English) the bill and proof of payment were written, and in what currency the bill was paid.
Diagnosis: What was the patient seen for?	Provide a diagnosis code and detailed description of illness or injury. (e.g., flu, broken leg, manic-depressive disorder, asthma)
Date(s) of Service	The date(s) the services were provided to the patient.
Procedures, Services, or Supplies Provided	Provide a procedure code and detailed description. (e.g., x-ray, office visit, lab work, leg cast, etc.)
Total Amount Paid	Total amount for which you are requesting reimbursement.
Proof of Service(s)	A document that demonstrates the service was actually rendered, listing date(s) of service(s) provided, and dollar amounts paid.
Proof of Payment	A document that demonstrates payment made by the member was received by the provider of service. Examples include: The front and back of the cancelled check written to the provider or the bank encoded front of the check written to the provider; a credit card statement or receipt; a statement from the provider, on the provider's letterhead with authorized signature, indicating payment was made; a receipt for purchased items, with the provider's name and address pre-printed on the receipt, with items listed and amount paid.

PROOF OF SERVICE AND PROOF OF PAYMENT EXAMPLES


Jane Doe, M.D.
County Medical
1234 Any Street
Anytown, MA 12345

Telephone: 555-555-7894
Tax ID# XX-XXXXX

For: Susan Sample

Diagnosis Code V.0208, Procedure Code 45678 for 1/23/12 and 2/16/12

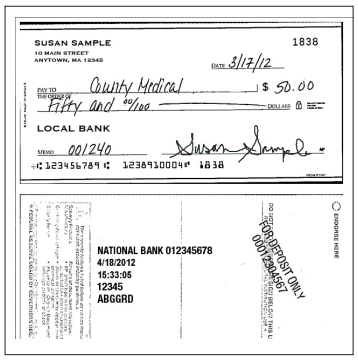
$25 per visit
$50 total

PAID IN FULL

Jane Doe, M.D.

LIC # 11122567

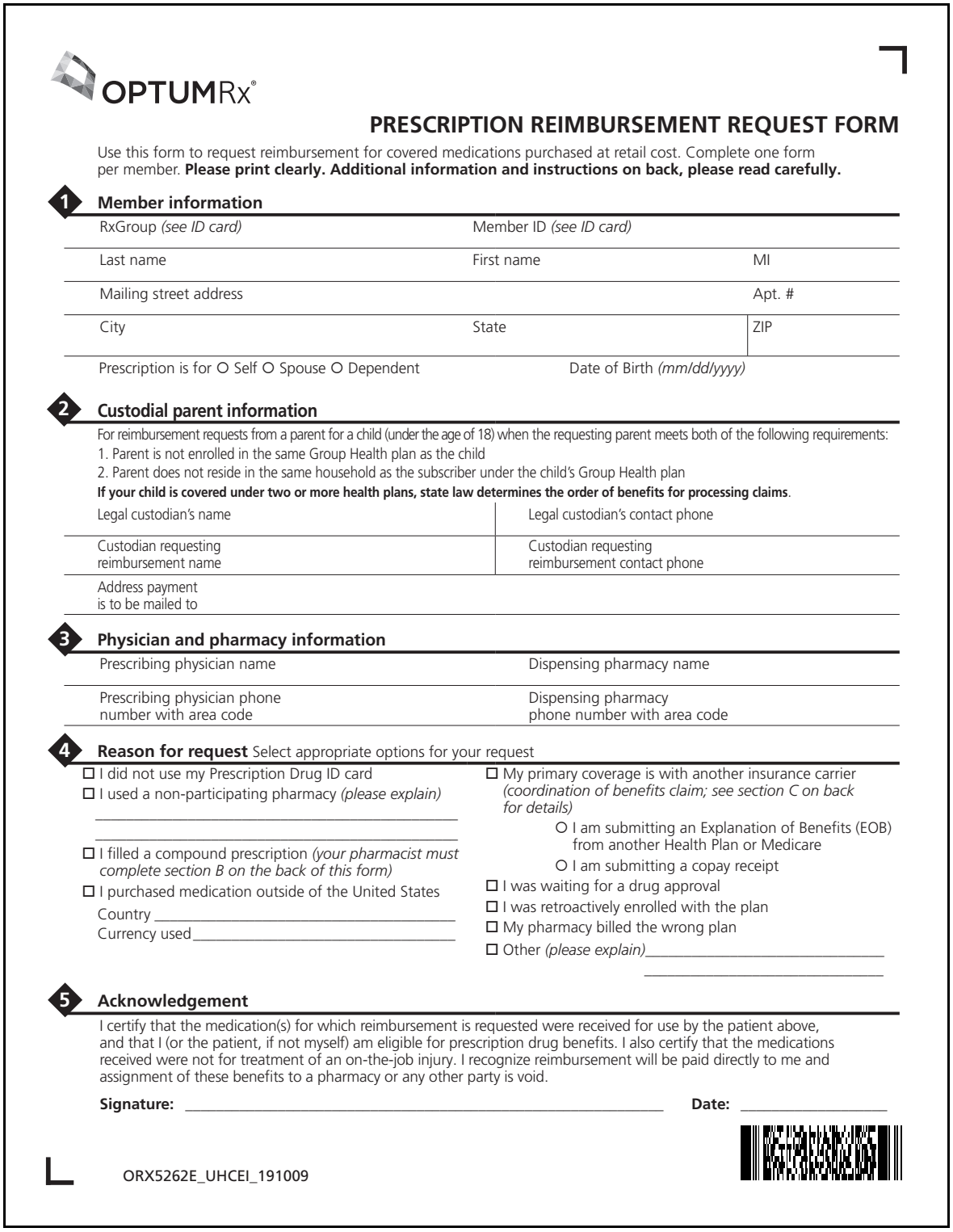
This example demonstrates both proof of payment and proof of service



This example demonstrates proof of payment

#18143-04/19

FIGURE 4: Member Reimbursement Form (page 2)



OPTUMRx®

PRESCRIPTION REIMBURSEMENT REQUEST FORM

Use this form to request reimbursement for covered medications purchased at retail cost. Complete one form per member. **Please print clearly. Additional information and instructions on back, please read carefully.**

1 Member information

RxGroup *(see ID card)*	Member ID *(see ID card)*	
Last name	First name	MI
Mailing street address		Apt. #
City	State	ZIP

Prescription is for O Self O Spouse O Dependent Date of Birth *(mm/dd/yyyy)*

2 Custodial parent information

For reimbursement requests from a parent for a child (under the age of 18) when the requesting parent meets both of the following requirements:
1. Parent is not enrolled in the same Group Health plan as the child
2. Parent does not reside in the same household as the subscriber under the child's Group Health plan

If your child is covered under two or more health plans, state law determines the order of benefits for processing claims.

Legal custodian's name	Legal custodian's contact phone
Custodian requesting reimbursement name	Custodian requesting reimbursement contact phone
Address payment is to be mailed to	

3 Physician and pharmacy information

Prescribing physician name	Dispensing pharmacy name
Prescribing physician phone number with area code	Dispensing pharmacy phone number with area code

4 Reason for request Select appropriate options for your request

- ☐ I did not use my Prescription Drug ID card
- ☐ I used a non-participating pharmacy *(please explain)*
  _____
  _____
- ☐ I filled a compound prescription *(your pharmacist must complete section B on the back of this form)*
- ☐ I purchased medication outside of the United States
  Country _____
  Currency used _____
- ☐ My primary coverage is with another insurance carrier *(coordination of benefits claim; see section C on back for details)*
  - O I am submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare
  - O I am submitting a copay receipt
- ☐ I was waiting for a drug approval
- ☐ I was retroactively enrolled with the plan
- ☐ My pharmacy billed the wrong plan
- ☐ Other *(please explain)*_____
  _____

5 Acknowledgement

I certify that the medication(s) for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me and assignment of these benefits to a pharmacy or any other party is void.

Signature: _____ **Date:** _____

ORX5262E_UHCEI_191009

FIGURE 5: OptumRx Prescription Reimbursement Form (page 1)OptumRx Prescription Reimbursement Form (page 1)

Instructions for submitting form

1. Include the original pharmacy receipt for each medication (not the register receipt). Pharmacy receipts must contain the information in Section A (below). If you do not have pharmacy receipts, ask your pharmacy to provide them to you.
2. Read the Acknowledgement (section 5) on the front of this form carefully. Then sign and date. Print page 2 of this form on the back of page 1.
3. Send completed form with pharmacy receipt(s) to: **OptumRx Claims Department, PO Box 650629, Dallas, TX 75265-0629**

Note: Cash and credit card receipts are not proof of purchase. Incomplete forms may be returned and delay reimbursement. Reimbursement is not guaranteed. Claims are subject to your plan's limits, exclusions and provisions.

Section A – Pharmacy receipts for reimbursement

Use the following checklist to ensure your receipts have all information required for your reimbursement request:

- ☐ Date prescription filled
- ☐ Name and address of pharmacy
- ☐ Prescribing physician name or ID number
- ☐ National Drug Code (NDC) number
- ☐ Name of drug and strength
- ☐ Prescription number (Rx number)
- ☐ Quantity

Section B – Pharmacy information *(for compound prescriptions ONLY)*

(Pharmacist must complete and sign)

- List VALID 11 digit NDC number (highest to lowest cost) in the box at right. Include EACH ingredient used in the compound prescription.
- For each NDC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL amount paid by the patient.
- Receipt(s) must be provided with this claim form.

* Individual quantities must equal the total quantity.
† Individual ingredient costs plus compounding fees must be equal to the total ingredient costs.

Rx#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity*	Ingredient Cost†
Compounding Fee		
Total		

X _____
Signature of Pharmacist

Section C – Coordination of benefits

You must submit claims within one year of date of purchase or as required by your plan.

When submitting an Explanation of Benefits (EOB) from another Health Plan or Medicare: If you have not already done so, submit the claim to the Primary Plan or Medicare. Once you receive the EOB, complete this form, submit the pharmacy receipts, and attach the EOB. The EOB must clearly indicate the cost of the prescription and amount paid by the Primary Plan or Medicare.

When submitting a copay receipt: If your Primary Plan requires you to pay a copayment or coinsurance to the pharmacy, then no EOB is needed. Just complete this form and submit the pharmacy receipts showing the amount you paid at the pharmacy. These receipts will serve as the EOB.

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

***Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment or a loss is subject to criminal and civil penalties.

***California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

42573A-042015
WF3664394_102720
ORX5262E_UHCEI_191009

FIGURE 5: OptumRx Prescription Reimbursement Form (page 2)

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通，我们提供一些免费服务，例如用其他语言书写的信件或大字体。您也可以要求与口译员对话。欲寻求帮助，请拨打您的 ID 卡上列出的免费电话号码。

FIGURE 5: OptumRx Prescription Reimbursement Form (page 3)

3 Dependent Eligibility

The following section presents Tufts Health Plan's policies for covering dependents. The term "dependent" includes the *Subscriber's* legal spouse, according to the law of the state in which you reside, or divorced spouse as required by Massachusetts law, domestic partner[5], "child", or disabled dependent. The events that qualify these dependents for enrollment are detailed below

Spouse also includes the spousal equivalent of the Subscriber who is the registered domestic partner, civil union partner, or other similar legally recognized partner of the *Subscriber* who resides in a state or municipal jurisdiction that provides such legal recognition/spousal equivalent rights.

Dependent Child 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.

A dependent's coverage terminates under the following circumstances:

- At the end of the month in which the dependent turns age 26
- When the subscriber's coverage terminates, whichever occurs first

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.

5 Domestic partner coverage can differ by employer group.

Enrollment Process

Disabled children are covered as dependents if they meet the following requirements:

- are currently disabled;
- live either with the Eligible Participant or spouse, in a licensed institution or group home; and
- remain financially dependent on the Eligible Participant.

To enroll a disable dependent, the subscriber must complete the two-part *Disabled Dependent Form*.

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.

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

  NOTE: When a subscriber remarries, the ex-spouse may be able to continue coverage under state law and/or COBRA.

- 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*, or submit a similar electronic transaction. 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 or electronic transaction within 60 days of the effective date to initiate the enrollment process.

Event	Necessary Documents
Open Enrollment	• Signed and completed *Member Enrollment Form*
Marriage and Add Domestic Partner	• Signed and completed *Member Enrollment Form*
Loss of Coverage	• Signed and completed *Member Enrollment Form*
Move into Service Area	• Signed and completed *Member Enrollment Form*
Mandated by Court Decree requiring dependent health care coverage	• Signed and completed *Member Enrollment Form* AND, UPON REQUEST, • Legal documentation mandating the subscriber to cover the dependent
Request to restrict employee/subscriber's access to a covered minor dependent's record	• Legal document specifying that the employee/subscriber has lost parental rights and indicating the personal representative to which full custody has been granted.
Adoption	• Signed and completed *Member Enrollment Form* AND, UPON REQUEST, • Legal documentation indicating when the child was placed with the subscriber for the purpose of adoption.
Birth	• Plan upgrade - signed and completed *Member Enrollment Form* OR • No plan upgrade - no written documentation is required for most groups member can simply call Member Services to add newborn.
Reinstatement of Dependent	• Signed and completed *Member Enrollment Form* AND • *Dependent Certification Form* completed by the subscriber
Qualifying Events under HIPAA/Section 125 Special Enrollment	• Contact your account manager with any questions

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.

Massachusetts Continuation of Coverage (MA COC)

Massachusetts's law requires employees and their enrolled dependents who work for companies with 2 to 19 employees to be offered continuation of coverage (MA COC).

Tufts Health Plan has delegated the administration and notification provisions of MA COC to groups with 2 to 19 employees. As such, you are required to notify your employees who elect Tufts Health Plan coverage of their rights under MA COC, and to administer MA COC for qualified beneficiaries who elect coverage.

Information and sample forms about MA COC are available on our Web site at tuftshealthplan.com or you can contact your account manager.

COBRA/MA COC Policies

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

- Following termination[6] or reduction in work hours, the enrolled employee and eligible dependents become eligible for COBRA/MA COC beginning on the first day following termination of group health benefits.
- A group member can change his or her COBRA/MA COC election during a group's open enrollment period. Therefore, someone with prior COBRA/MA COC, 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/MA COC because they lost dependent status (e.g., aged out) cannot be put on COBRA/MA COC within their former family membership. They would be eligible as an individual and must submit a *Member Enrollment Form*.

6 Except for gross misconduct.

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[7].

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

COBRA/MA COC Administrative Steps

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

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/MA COC election, you must complete a *Member Change Form* listing the subscriber's social security number and/or member ID, and name, plan code, effective date, and reason code 108.

Termination from COBRA

To terminate a member from COBRA/MA COC, 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.
- Member can reside outside of the service area provided that your group does not exceed the permitted out-of-area membership as described in *Tufts Health Plan's Provider Access Area* in Chapter 2 of this manual.

When an employee's dependent elects individual COBRA continuance, the dependent must complete a *Member Enrollment Form* and submit it to Tufts Health Plan's Enrollment department.

7 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.

Individual Coverage

When a member's coverage under federal or state continuation 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 800-462-0224 for more information.

5 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:

- 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 your invoices are ready and available for viewing and payment

Premium Billing Policies

Tufts Health Plan does not prorate based on effective date of change. Member charges for additions, terminations, and plan changes are based on the effective date of the change and a wash rule system. 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 15th day of the monthly billing cycle. Tufts Health Plan does not bill that month's premium for subscribers who are effective after the 15th day of the monthly billing cycle.

Terminations from the Plan

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

ACH	WIRE
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 #9924191	Account #9924191

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.

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
P.O. Box 506
Canton, MA 02021

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.

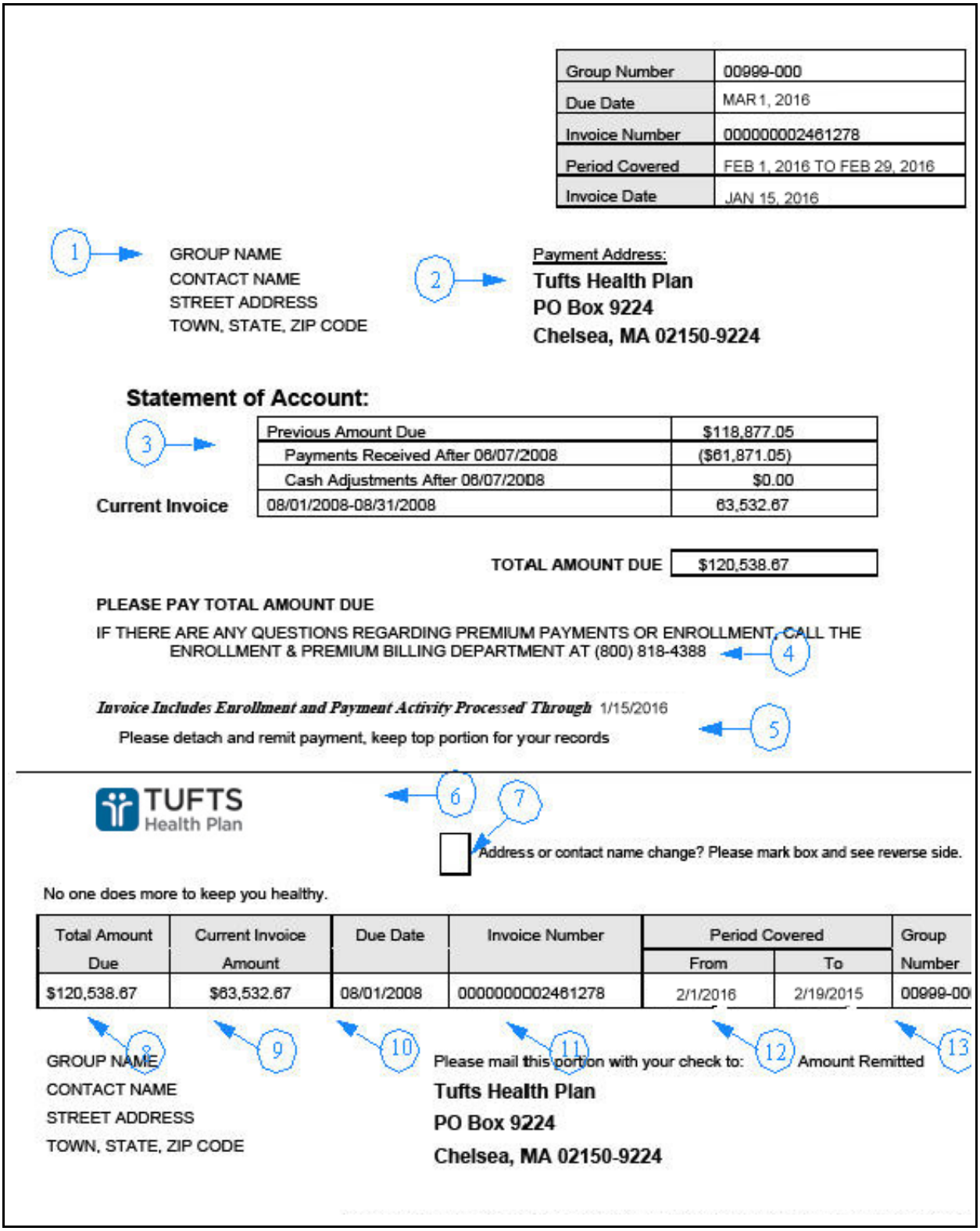
Toll-Free and Fax Numbers

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, 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.

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



Group Number	00999-000
Due Date	MAR 1, 2016
Invoice Number	000000002461278
Period Covered	FEB 1, 2016 TO FEB 29, 2016
Invoice Date	JAN 15, 2016

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 →

Previous Amount Due	$118,877.05
Payments Received After 06/07/2008	($61,871.05)
Cash Adjustments After 06/07/2008	$0.00
Current Invoice 08/01/2008-08/31/2008	63,532.67

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 ← 4

Invoice Includes Enrollment and Payment Activity Processed Through 1/15/2016 ← 5

Please detach and remit payment, keep top portion for your records

TUFTS Health Plan ← 6

7 → ☐ 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	$63,532.67	08/01/2008	0000000002461278	2/1/2016	2/19/2015	00999-00

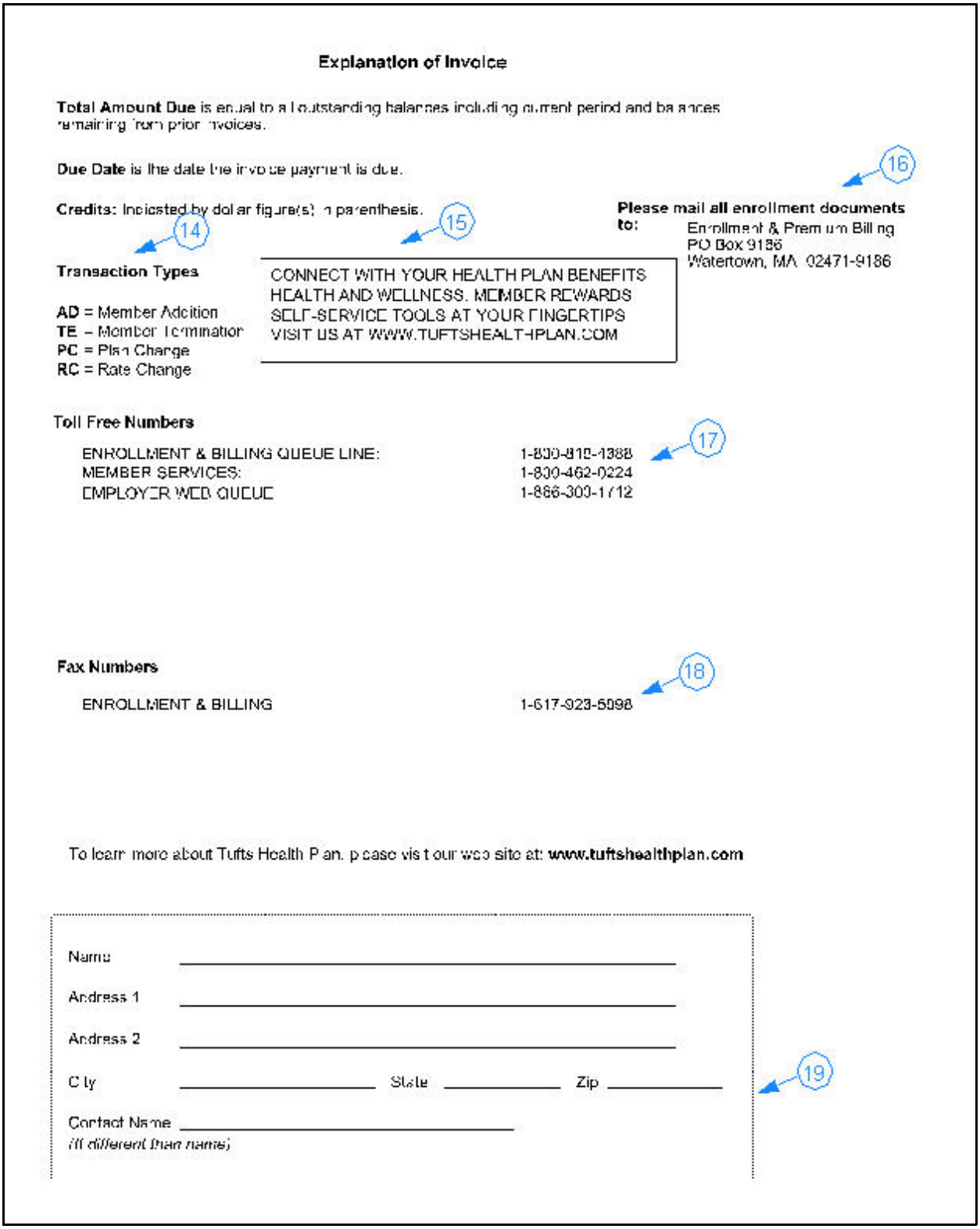
8 9 10 11 12 13

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

Please mail this portion with your check to: Amount Remitted

Tufts Health Plan
PO Box 9224
Chelsea, MA 02150-9224

FIGURE 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.

16

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

14

Transaction Types

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

15

CONNECT WITH YOUR HEALTH PLAN BENEFITS
HEALTH AND WELLNESS. MEMBER REWARDS
SELF-SERVICE TOOLS AT YOUR FINGERTIPS
VISIT US AT WWW.TUFTSHEALTHPLAN.COM

Toll Free Numbers

17

ENROLLMENT & BILLING QUEUE LINE:	1-800-816-1388
MEMBER SERVICES:	1-800-462-0224
EMPLOYER WEB QUEUE	1-866-300-1712

Fax Numbers

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ENROLLMENT & BILLING	1-617-923-5998

To learn more about Tufts Health Plan, please visit our web site at: **www.tuftshealthplan.com**

Name _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip _____

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Contact Name _____
(If different than name)

FIGURE 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.

This termination for non-payment of premium is not considered a "Rescission" under Federal Health Care Reform.

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
- Directory of Healthcare Providers (available on request)[8]
- *OptumRx Prescription Mail-In Order Form* (available on request)

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 part of their employer's contract with Tufts Health Plan.

Secure Online Member Account

All members should set up their secure account to quickly access their health plan benefits information by visiting mytuftshealthplan.com or downloading the Tufts Health Plan mobile app from the App Store or Google Play. Through their secure account, members can easily:

- View their coverage and costs
- Select or change their Primary Care Provider (PCP)
- Review their claims, referrals, and authorizations
- Compare costs of services and doctors

8 Members can call Member Services at 800-462-0224 to request this information.

Provider Directories

The Directory of Healthcare Providers lists contracting providers an other medical providers according to the city or town in which they practice. It also includes the hospital affiliation and whether they are PCPs or specialists. Provider directories and provider search capabilities are available to our members online at tuftshealthplan.com/find-a-doctor.

OptumRx Prescription Mail-In 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 at 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 at tuftshealthplan.com.

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. Members also have the right to file an external appeal. Specifically, members who are dissatisfied with the internal appeal decision may write to Tufts Health Plan request an external review. Tufts Health Plan will coordinates an independent review of eligible appeals through an external review agency. The external review agency will notify the member of the decision, which is binding on the Plan.

Process

The 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*) or a Tufts Health Plan member services specialist at800-462-0224, or visit Tufts Health Plan's Web site at tuftshealthplan.com.