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 9186 • Watertown, MA 02471-9186

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_____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID.

TUFTS Health Plan

This is a Massachusetts Large Group Plan

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2010 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2010. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi.

This health insurance issuer believes this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, restrictions on annual limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 800-462-0224. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see https://www.tuftshealthplan.com or call 800-462-0224. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 800-462-0224 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0; per plan year.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	This plan does not have a deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See https://www.tuftshealthplan.com, "Find a doctor, hospital…" or call 800-462-0224 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per plan year)**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not covered	None
	Specialist visit	$15 copay/visit	Not covered	Prior authorization may be required.
	Preventive care/ screening/ immunization	$15 copay/visit	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Prior authorization may be required.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior authorization is required.
If you need drugs to treat your illness or condition	Tier 1 - Generic drugs	$10 copay/fill (retail); $10 copay/fill (mail order)	Not covered	Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations.
	Tier 2 - Preferred brand and some generic drugs	$25 copay/fill (retail); $25 copay/fill (mail order)		
	Tier 3 - Non-preferred brand drugs	$45 copay/fill (retail); $45 copay/fill (mail order)		
More information about prescription drug coverage is available at www.tuftshealthplan.com **This is a Massachusetts Large Group Plan**	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy	Not covered	Limited to a 30-day supply. Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Some surgeries require prior authorization in order to be covered.
	Physician/surgeon fees	No charge	Not covered	

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per plan year)**
If you need immediate medical attention	Emergency room care	$50 copay/visit		Cost share waived if admitted.
	Emergency medical transportation	No charge		Some emergency transportation requires prior authorization to be covered
	Urgent care	$15 copay/visit		Services with non-participating providers are only covered out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Some hospitalizations require prior authorization to be covered.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	Not covered	Prior authorization may be required.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office Visits	No charge for routine outpatient office visits	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Participating Provider (You will pay the least)**	**Non-participating Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information (limits apply per plan year)**
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Prior authorization is required.
	Rehabilitation services	$15 copay/visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
	Habilitation services	$15 copay/visit	Not covered	Short-term physical and occupational therapy limited to 30 visits for each type of service per year. No set limit on speech therapy. Prior authorization may be required.
	Skilled nursing care	No charge	Not covered	Limited to 100 days per year. Prior authorization is required.
	Durable medical equipment	No charge	Not covered	Prior authorization may be required.
	Hospice services	No charge	Not covered	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit	Not covered	Limited to one visit every 12 months with an EyeMed vision care provider.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care/custodial care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Treatment that is experimental or investigational, for educational or developmental purposes, or does not meet Tufts Health Plan Medical Necessity Guidelines (with limited exceptions specified in your plan document)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (spinal manipulation)
- Hearing aids (age 21 or younger only)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or https://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit https://www.HealthCare.gov or call 1-800-318-2596. If you are a Massachusetts resident, contact the Massachusetts Health Connector at https://www.mahealthconnector.org.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Tufts Health Plan Member Services at 800-462-0224. Or you may write to us at Tufts Health Plan, Appeals and Grievances Department, 705 Mt. Auburn St., P.O. Box 9193, Watertown, MA 02471-9193. Additionally, a consumer assistance program can help you file your appeal. Contact: MA: Health Care for All, One Federal Street, Boston, MA 02110, 1-800-272-4232, https://www.hcfama.org.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-462-0224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-462-0224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-462-0224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-462-0224.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Plan coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Plan coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$60**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Plan coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM

DISCRIMINATION IS AGAINST THE LAW

Tufts Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tufts Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tufts Health Plan at 800-462-0224.

If you believe that Tufts Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tufts Health Plan, Attention:
Civil Rights Coordinator Legal Dept.
705 Mt. Auburn St. Watertown, MA 02472
Phone: 888-880-8699 ext. 48000, [TTY number — 800-439-2370 ext. 711]
Fax: 617-972-9048, Email: OCRCoordinator@tufts-health.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For no cost translation in English, call the number on the top of page 1.

Arabic	للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون بالجزء العلوي من الصفحة رقم 1
Chinese	若需免費的中文版本，請撥打第 1 頁頂端的電話號碼。
French	Pour demander une traduction gratuite en français, composez le numéro indiqué en haut de la page 1.
German	Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer oben auf Seite 1 an.
Greek	Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην κορυφή της σελίδας 1.
Haitian Creole	Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.
Italian	Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato nella parte superiore di pagina 1.
Japanese	日本語の無料翻訳については 1 ページ目の一番上にある番号に電話してください。
Khmer	**សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជាភាសាខ្មែរសូមទូរស័ព្ទទៅកាន់លេខដែលនៅផ្នែកខាងលើនៃទំព័រទី1។**
Korean	한국어 무료 통역을 원하시면, 1 페이지 맨 위에 번호로 전화 하십시오.
Laotian	ສໍາລັບການແປພາສາລາວທີ່ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍ, ໃຫ້ໂທຫາເບີໂທທີ່ຢູ່ດ້ານເທິງຂອງໜ້າທີ 1.
Navajo	Doo bąąh ilíní da Diné k'ehjí álnéehgo, hodiilnih béésh bee haní'é binumber díí naaltsoos bikáá' wódahdi.
Persian	**برای ترجمه رایگان به فارسی، به شماره تلفن مندرج در بالای صفحه1زنگ بزنی د**
Polish	Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer zamieszczony u góry strony 1.
Portuguese	Para tradução grátis para português, ligue para o número no topo da página 1.
Russian	Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному сверху на стр. 1.
Spanish	Por servicio de traducción gratuito en español, llame al número indicado en la parte superior de la página 1.
Tagalog	Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa itaas ng unang pahina 1.
Vietnamese	Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên đầu trang 1.

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