Members

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Tufts Medicare Preferred HMO members are required to choose a PCP and are expected to transfer their medical records (if the elected PCP is not their current PCP). If the member does not choose a PCP upon enrollment, Tufts Health Plan will assign a PCP to the member. If new members are receiving ongoing medical care, they are advised to contact their new PCP as soon as their membership becomes effective with Tufts Health Plan. Any new members who are not receiving ongoing care are advised to call their PCP to schedule a routine physical examination. New members are encouraged to receive an initial health assessment within 90 days of the effective date of enrollment. Tufts Health Plan provides each medical group with a monthly eligibility listing report that identifies both new and existing members who have a provider within the group designated as their PCP. The PCP may elect to contact new members who appear on the eligibility listing report.

Tufts Medicare Preferred PPO members are encouraged but not required to select a PCP upon joining the plan. PPO members do not require referral for in- or out-of-network services. However, members are strongly encouraged to ask their PCP for assistance in selecting a network specialist or supplier and to follow up with their PCP, if they have one, after any specialist visits. Prior authorization is required for certain in-network services. Prior authorization is not required for out-of-network services. However, members are encouraged to ask for a pre-visit coverage decision to confirm that the out-of-network services are covered and are medically necessary. Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and the member or ordering provider will be responsible for the entire cost. All Tufts Health Plan Senior Care Options (SCO) members are covered for services under Medicare and Medicaid. Tufts Health Plan SCO members have no cost share (i.e., copays, coinsurance, deductibles) or other out-of-pocket costs for covered services.

Tufts Medicare Preferred HMO and PPO members may choose to receive their elected pharmacy benefits through Tufts Health Plan.

Dominion National provides dental services for Tufts Medicare Preferred HMO members, while Tufts Health Plan SCO members receive dental benefits from providers in the Tufts Health Plan DentaQuest network. Tufts Medicare Preferred HMO members and Tufts Health Plan SCO members receive routine eye care from providers in the Tufts Health Plan EyeMed network. Tufts Medicare Preferred PPO members may also receive covered services including vision and Medicare-covered dental services from network providers. However, PPO members are not limited to network providers and can receive covered services from out-of-network providers anywhere in the United States including Puerto Rico. Cost shares for out-of-network services are generally higher than for in-network services. Pharmacy, Medicare-covered dental and vision care providers are listed in the provider directories.

Tufts Health Plan follows federal and state privacy regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to safeguard the privacy of members' protected health information (PHI). Tufts Health Plan's Notice of Privacy Practices outlines member privacy rights and describes how Tufts Health Plan collects, uses, and discloses PHI. Refer to the Legal, Security, and Privacy Practices section of our website for more information.

Coverage Options

Tufts Medicare Preferred HMO and PPO

Tufts Medicare Preferred HMO and PPO plans offer various medical and prescription drug coverage options for its members. HMO plans cover all medically necessary Original Medicare benefits as well as supplemental benefits. Individuals may not purchase prescription drug coverage without medical coverage.

In addition to the Tufts Medicare Preferred HMO medical coverage, members may have the Tufts Health Plan Medicare Preferred Dental Plan embedded or the Tufts Health Plan Medicare Preferred Dental Option rider administered by Dominion National. Members with the dental option rider purchase for an additional monthly premium.

Certain Medicare-covered services performed by a dentist or oral surgeon are included in the member's medical coverage.

Tufts Health Plan covers all services that the member currently receives under Medicare, as applicable. Limitations may apply to some services. Refer to the Plans section of the Tufts Medicare Preferred website for additional information.

Changes to covered services are communicated in writing to network providers and members.

Tufts Health Plan SCO

Tufts Health Plan SCO covers all services that the member currently receives under MassHealth and Medicare. Limitations may apply to some services. Refer to the Plans section of the Tufts Health Plan Senior Care Options for additional information.

Changes to covered services are communicated in writing to network providers and members.

Eligibility

Individuals joining Tufts Medicare Preferred must meet specific requirements set by Centers for Medicare & Medicaid Services (CMS). Enrollment in Tufts Health Plan SCO is voluntary and open to individuals age 65 or older who qualify for Medicare and Medicaid and who meet requirements set by the state of Massachusetts.

Enrollment

Tufts Medicare Preferred

Members enrolling in Tufts Medicare Preferred may use one of the following methods:

- Online enrollment tool
- Mail or fax a completed enrollment form to Tufts Health Plan
- Call Tufts Health Plan at 800-890-6600 (TTY 711) 7 days a week, 8 a.m. - 8 p.m.
  (Apr. 1 – Sept. 30, representatives are available Monday–Friday, 8 a.m. - 8 p.m.)
- Attend a local informational meeting with a licensed Medicare Agent
- Enroll through Medicare by calling 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) 24 hours a day, 7 days a week or online via the CMS Medicare Online Enrollment Center

Completed election forms received by Tufts Health Plan on or before the last day of the month will generally be effective the first day of the next calendar month.

Enrollment Rules

Tufts Medicare Preferred includes limits on when and how often individuals can change the way they obtain Medicare for the plan, in accordance with the CMS Medicare Managed Care Manual. Switching from one plan to another plan Tufts Health Plan offers, or to a plan offered by another MAO, is considered a change.

Enrollment Periods and Effective Dates

Initial Coverage Election Period (ICEP): The time during which an individual who is newly eligible for Medicare Advantage can make an initial election to enroll in a Medicare Advantage Plan. This period begins 3 months before the individual's first entitlement to both Medicare Part A and Part B and ends on the last day of the month preceding entitlement to both Part A and Part B, or the last day of the individual's Part B enrollment period (whichever date is later).

The initial enrollment period for Part B is the 7-month period that begins 3 months before the month that an individual meets the eligibility requirements for Part B and ends 3 months after the month of eligibility.

Initial Enrollment Period for Part D (IEP for Part D): The time during which an individual is first eligible to enroll in a Part D plan. Generally, an individual is eligible to enroll in a Part D plan when the individual is entitled to Part A or the individual is enrolled in Part B and permanently resides in the service area of a Part D plan.

Annual Enrollment Period (AEP): The time from October 15 through December 7 each year when individuals enrolled in Medicare will have an opportunity to change the way they participate in Medicare and to add or drop Medicare prescription drug coverage effective January 1st.

Medicare Advantage Open Enrollment Period (MA OEP): From January 1 through March 31 each year, anyone enrolled in a Medicare Advantage Plan (except a Medicare Savings Account (MSA) or other Medicare health plan type) may enroll in another MA plan or disenroll from their current plan and return to Original Medicare. MA OEP also applies to new Medicare beneficiaries who are enrolled in a MA plan during their ICEP; this MA OEP occurs during the month of entitlement to Part A and Part B to the last day of the 3rd month of entitlement. Individuals may make only one election during the MA OEP. Individuals may add or drop Part D coverage during the MA OEP. Individuals enrolled in either MA-PD or MA-only plans can switch to: MA-PD, MA-only or Original Medicare (with or without stand-alone Part D plan).

The effective date for an MA OEP election is the first of the month following receipt of the enrollment request. The MA OEP does not provide an opportunity for an individual enrolled in Original Medicare to join a MA plan, nor does it allow for Part D changes for individuals enrolled in Original Medicare, including those enrolled in stand-alone Part D plans. If individuals join a Medicare Prescription Drug Plan, they will be automatically disenrolled from Tufts Medicare Preferred and returned to Original Medicare.

Generally, individuals cannot make any other changes during the year unless they meet special exceptions (e.g., if a member moves out of the plan's service area or has both Medicare and Medicaid coverage). If a member has Medicare and Medicaid coverage, they may change to another plan at any time. If a member lives in a long-term care facility (such as a nursing home) they can also change to another plan at any time.

If an individual joins another Medicare plan, including a Medicare Prescription Drug Plan, they will be disenrolled from Tufts Medicare Preferred when enrollment in the new plan begins.

If a member leaves their current plan and does not join a plan that offers Medicare Prescription Drug Coverage or a Medicare Prescription Drug Plan, and they do not have prescription drug coverage that offers the same or better benefits as the basic Medicare Prescription Drug Coverage, the member may have to pay a Medicare Part D late enrollment penalty (LEP) if they decide to join later, resulting in a higher monthly premium.

Tufts Health Plan SCO

A qualified individual may voluntarily enroll in Tufts Health Plan SCO at any time during the year. Membership is effective on the first calendar day of the month following the approval of the member's enrollment and renewal occurs on the anniversary of the member's effective date.

Disenrollment

Tufts Medicare Preferred

Tufts Health Plan may not, either orally or in writing or by any action or inaction, request or encourage any Tufts Medicare Preferred member to disenroll. While a MAO may contact members to determine the reason for disenrollment, the MAO may not discourage members from disenrolling after they indicate their desire to do so. The MAO must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

Disenrollment is effective on the first calendar day of the month following the month in which the notice is received. Disenrollment requests received during AEP become effective when the new plan's coverage begins on January 1 of the following year.

Voluntary Disenrollment by Member

Tufts Medicare Preferred members may voluntarily disenroll in accordance with the approved election periods noted in the enrollment rules. To disenroll from a plan, members must do one of the following:

- Hand-deliver, mail or fax a signed written form to Tufts Health Plan
- Call 1-800-MEDICARE (800-633-4227) (TTY: 877-486-2048)
- Join another Medicare Advantage PDP or Prescription Drug Plan during a valid enrollment period to be automatically disenrolled from Tufts Medicare Preferred coverage.

Note: If a Tufts Medicare Preferred member verbally requests to disenroll, Tufts Health Plan must instruct the member to make the request through one of the methods described above.

Required Involuntary Disenrollment

Tufts Health Plan must disenroll a Tufts Medicare Preferred member in the following situations:

- The member has a change in residence (including incarceration) that makes them ineligible to be a member of Tufts Medicare Preferred. A Tufts Medicare Preferred member disenrolled under this provision has a special election period to elect a different Medicare Advantage Plan or to return to Original Medicare. A member who fails to make an election will be deemed to have elected Original Medicare.
- The member loses entitlement to either Medicare Part A or Part B
- The member dies

- The Tufts Medicare Preferred contract is terminated, or if the member resides in an area where the plan is no longer offered. A Tufts Medicare Preferred member disenrolled under this provision has a special election period (SEP) to elect a different Medicare Advantage Plan or to return to Original Medicare. A member who fails to make an election is deemed to have elected Original Medicare.
- The member fails to pay their Part D-IRMAA and CMS notifies the plan to effectuate the disenrollment
- The member is not lawfully present in the United States.

Optional Involuntary Disenrollment

Tufts Health Plan may disenroll a Tufts Medicare Preferred member from a Medicare Advantage Plan in the following situations:

- Premiums are not paid on a timely basis
- The member engages in disruptive behavior
- The member provides fraudulent information on an election form, permits abuse of a Tufts Medicare Preferred enrollment card, or the member engages in other fraudulent conduct with respect to the program.

Disenrollment Procedures for Employer Group Health Plans

When an employer group terminates its contract with an MAO, or determines that an enrollee in its program is no longer eligible to participate in the employer group plan, Tufts Medicare Preferred may disenroll beneficiaries by following the procedure in either Option 1 or Option 2:

- **Option 1:** Enroll the individual in another Medicare Advantage Plan (i.e., individual plan) offered by the same MAO unless the beneficiary makes another choice. The individual must be eligible to enroll in this plan, including residing in the plan's service area. The individual plan selected for this option must be the same type of plan.
- **Option 2:** Disenroll the individual from the employer/union-sponsored Medicare Advantage Plan to Original Medicare following prospective notice.

Tufts Health Plan SCO

Voluntary Disenrollment

Members may voluntarily disenroll at any time for any reason for Tufts Health Plan SCO members with a valid election. Disenrollment is effective on the first calendar day of the month following the month in which the notice is received. To voluntarily disenroll from the plan, members must do one of the following:

- Hand-deliver, mail or fax a signed written notice to Tufts Health Plan
- Call 1-800-MEDICARE (1-800-633-4227) (if individual is Medicare-eligible)
- Join another SCO plan from another Medicare Advantage Organization

If a member verbally requests to disenroll, Tufts Health Plan will instruct the member or their Designated Representative to make the request in writing on a signed disenrollment form, including an electronic form.

Involuntary Disenrollment

Occasionally, it is necessary for Tufts Health Plan to involuntarily disenroll a Tufts Health Plan SCO member. Reasons for involuntary disenrollment may include:

- Loss of MassHealth eligibility. Tufts Health Plan can help members apply to regain their eligibility by contacting the applicable MassHealth Enrollment Center.
- Member no longer meets SCO program participation requirements
- Member has confirmed to the plan that they have relocated out of the service area

- Fraud or abuse, which occurs when the member provides fraudulent information on an Enrollment form or willfully misuses or permits another person to misuse the member's ID card
- Disruptive behavior, when the member's continued enrollment seriously impairs the plan's ability to furnish services to either this member or other members

Membership cannot be cancelled due to the status of the member's health.

Member Education

Tufts Health Plan's member education outreach includes literature that helps certain prospective and active members understand how to utilize their health insurance benefits. Members receive an identification card in addition to benefit materials containing information on plan benefits, cost-sharing amounts, exclusions, and plan policies and procedures, including the evidence of coverage (EOC), which is made available to the member upon enrollment and annually thereafter.

Member Identification Cards

Members are encouraged to carry their Tufts Medicare Preferred or Tufts Health Plan SCO ID card at all times. If a member has enrolled but has not received their ID card, the pink copy of the election form may be used as temporary identification.

Health Risk Assessment

As part of the Health Risk Assessment program, newly enrolled members are provided a Health Needs Questionnaire. Completing the questionnaire is voluntary. The purpose of the program is to profile members' health risk status at enrollment and share information regarding member risk with members' health care providers. Tufts Health Plan ultimately expects the sharing of information to lead to better management of care, which will result in improved health outcomes. Members are also screened for eligibility for additional care management services.

Newly enrolled Tufts Health Plan SCO members receive a Health Risk Assessment within 30 days of enrollment and a re-assessment at prescribed intervals thereafter, depending on the complexity level of the member's health needs. The content of the assessment identifies medical, functional, cognitive, psychosocial and mental health needs of the member. Information from the Health Risk Assessment is used in the development of and updates to the members' care plan.

Advance Directives

The federal Patient Self-Determination Act requires certain facilities, including MAOs, to document whether or not a member has executed an advance directive. An advance directive is a written instruction relating to the provision of health care when the member is unable to communicate their wishes regarding medical treatment. This document is sometimes called a living will, healthcare proxy, or durable power of attorney for healthcare. A sample appointment of representative (AOR) form is distributed to new Tufts Health Plan members.

Tufts Health Plan maintains written policies and procedures that provide for community education regarding advance directives. Members receive educational materials upon enrollment that define advance directives, emphasizing that advance directives are designed to enhance an incapacitated individual's control over medical treatment decisions. Applicable state law concerning advance directives is also included in the materials.

To ensure compliance with the provisions of the federal Patient Self-Determination Act, Tufts Health Plan requires that providers document whether a member has executed an advance directive and that the advance directive must be a prominent part of the member's medical record.

Member Rights and Responsibilities

Tufts Health Plan makes a Member Rights and Responsibilities statement available to members. This document explains the member's responsibility to adhere to Tufts Health Plan policies and informs members that they have certain rights regarding their care, such as access to and participation in decisions about their care. Members may refer to their Evidence of Coverage (EOCs) or contact Senior Products Member Services at the number listed on the member's EOC for additional information on this statement.

Know the Member's Rights and Responsibilities

As part of our strong commitment to quality care and customer service, Tufts Health Plan wants members to remain informed about their rights and responsibilities. We developed the following list to help members be fully informed of their membership rights and responsibilities. Additional information about the grievance process, policies, procedures, and member records can be found in members' EOCs.

Member Rights

Members have the right to:

- Receive information about Tufts Health Plan including its services, health plan staff and their qualifications, contractual relationships, benefits, member rights and responsibilities, healthcare providers, policies, and procedures
- Choose covered services for which they are eligible
- Be informed by their physician or other healthcare provider regarding their diagnosis, treatment, and prognosis in terms that are understandable
- Receive sufficient information from their healthcare providers to enable them to give informed consent before beginning any medical procedure or treatment
- Have a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Participate with practitioners in decisions regarding their healthcare
- Be treated courteously, respectfully and with recognition of their dignity and need for privacy
- Be free from abuse, neglect, and exploitation
- Refuse treatment, drugs or other procedures recommended by Tufts Health Plan providers to the extent permitted by law and to be informed of the potential medical consequences of refusing treatment
- Be covered for emergency services in cases where a prudent layperson, acting reasonably, would believe that an emergency medical condition exists
- Have reasonable access to essential medical services
- Decline participation in or disenroll from services offered by Tufts Health Plan
- Expect that all communications and records pertaining to their healthcare are treated as confidential in accordance with Tufts Health Plan's Notice of Privacy Practices
- Select a doctor from Tufts Health Plan's directory of healthcare providers who is accepting new patients and expect the physician to provide covered healthcare services. Tufts Medicare Preferred PPO members have the right not to select a PCP or to select a non-contracted PCP.
- Obtain a copy of their medical records from their providers, in accordance with the law
- Use the Tufts Health Plan member satisfaction process described in their benefit document (which include timeliness for responding to and resolving complaints and quality issues) to voice a concern or complaint about the organization or the care it arranges and to appeal coverage decisions
- Make recommendations regarding the organization's members' rights and responsibilities policy

Member Responsibilities

Members have a responsibility to:

- Treat network providers and their staff with the same respect and courtesy that members expect for themselves
- Ask questions and seek clarification to understand their illness or treatment
- Cooperate with Tufts Health Plan so that we may administer member benefits in accordance with their benefit document
- Obtain services from an in-network provider except in a medical emergency, (e.g., a serious injury, or onset of a serious condition that prevents them from calling their PCP in advance)
  This applies to HMO and PPO members seeking coverage at the authorized level of benefits. Tufts Medicare Preferred PPO members are not required to receive services from in-network providers. They can receive services from any provider within the U.S. including Puerto Rico. Out-of-network cost-share applies to services received out-of-network.
- Follow plans and instructions for care that they have agreed to with their practitioners
- Obtain appropriate authorization(s) from their Tufts Health Plan PCP before seeking care, except in the case of urgent/emergency care
  This applies to HMO members seeking coverage at the authorized level of benefits. Tufts Medicare Preferred PPO members do not need a referral or prior authorization to receive out-of-network services. However, members are encouraged to ask for a pre-visit coverage decision to confirm that the out-of-network services are covered and are medically necessary. Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and the ordering provider may be responsible for the entire cost; the member cannot be balance billed
- Keep scheduled appointments with healthcare providers or give adequate cancellation notice
- Express concerns or complaints through the Tufts Health Plan member satisfaction process described in their benefit document
- Familiarize themselves with their Tufts Health Plan benefits, policies and procedures by reading distributed materials and by calling Member Services with any questions
- Supply, to the extent possible, information needed by their healthcare providers and Tufts Health Plan and to the practitioners who provide their care
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals, to the degree possible

Billing Members

Collecting Payment

Providers should bill Tufts Health Plan and collect member cost sharing payment as follows, noting Tufts Health Plan SCO members have no cost sharing or out of pocket costs for covered services**.**

Deductible and Coinsurance

Members are not required to make payment for any portion of the deductible or coinsurance at the time services are rendered. For services that are subject to a deductible and/or coinsurance, providers should:

- Bill Tufts Health Plan within 60 days from the date of service.
- Upon receipt of your Tufts Health Plan Explanation of Payment (EOP) report, determine the amount the member is responsible for, as indicated by the EOP.

Tufts Health Plan will send an Explanation of Benefits (EOB) to the member showing the services provided by the provider and any amount the member owes to the provider; however, the EOB is not a bill.

Copayment

In most cases, copayment is payable, whether or not the deductible has been met, until the annual out-of-pocket maximum has been reached. Hospitals should wait until they receive their EOP to determine whether a deductible or a copayment applies to an emergency room visit. For services that require a copayment, providers should:

- Collect the copayment listed on the member's ID card at the time of service.
- Bill Tufts Health Plan within 60 days from the date of service.

Tufts Health Plan's reimbursement will be the allowed amount minus the copayment.

Maximum Out-of-Pocket Expenses (MOOP)

The term Maximum Out-of-Pocket (MOOP) refers to the limit on how much a Medicare Advantage Plan enrollee must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. Deductibles, copayments, and coinsurance comprise member expenses for purposes of MOOP. MOOP is not applicable to the member‘s Medicare Part B Premium or Part D drug benefit.

All our health plans have a MOOP. If a member reaches a point where they have paid the MOOP during a calendar year (coverage period), the member will not have to pay any out-of- pocket costs for the remainder of the year for covered Medicare Part A and Part B services. If a member reaches this level, the Plan will no longer deduct any applicable member expenses from the provider‘s reimbursement.

The MOOP can vary by Plan and may change from year to year. You may confirm that a member has reached their MOOP by contacting the Provider Services at 800-279-9022.

Qualified Medicare Beneficiary (QMB) Members

The Qualified Medicare Beneficiary (QMB) program put in place by the Centers for Medicare and Medicaid Services (CMS) assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copayments. As a reminder, under the QMB program enrollees are exempt from cost-sharing liability.

Federal law bars Medicare providers and suppliers, including pharmacies, from billing an individual enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Part A and Part B cost-sharing under any circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.) Providers and suppliers, including pharmacies, may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, states may limit Medicare cost-sharing payments, under certain circumstances. Persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

Prohibition of Balance Billing for Covered Services

As a participating provider you have entered into a contractual agreement to accept payment directly from Tufts Health Plan. Payment from the plan constitutes payment in full, except for applicable deductible, copayments, and/or co-insurance as listed on the EOB/EOP.

You may not bill members for the difference between actual billed charges and your contracted reimbursement rate. This practice, called, “balance billing,” is prohibited for covered services.

Failure to notify the plan of a service that requires prior authorization will result in payment denial. In this scenario, members may not be balance billed and are responsible only for their applicable cost-sharing.

Billing Members for Non-covered Services

Sometimes you and the member may decide that a service or treatment is the best course of care, even if it is not covered by Original Medicare, Tufts Medicare Preferred, or Tufts Health Plan SCO. You cannot directly bill the member unless the member has been formally advised by the plan that the service will not be covered.

Before you can bill a member for non-covered medical services or prescription drugs, you or the member must request a plan review. This requires submitting:

- An organization determination for medical services, or
- A coverage determination for prescription drugs.

The plan will notify both you and the member of its decision.

If the plan determines that the service will not be covered and the member still wants to proceed, you must obtain the member's informed written consent before billing them. This consent must specify the non-covered service and the exact amount the member will be charged.

Please note that the process of submitting an Advance Beneficiary Notice of Non-coverage (ABN) is applicable for Original Medicare only, and is not considered a valid form of denial notice for a Medicare Advantage member.

See the *Referrals, Prior Authorizations and Notifications* chapter for the process for submitting an organization determination for medical services and a coverage determination request for prescription drugs.

Confidentiality of Protected Health Information

Tufts Health Plan follows federal and state privacy regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to safeguard the privacy of members' protected health information (PHI). Tufts Health Plan's Notice of Privacy Practices outlines member privacy rights and describes how Tufts Health Plan collects, uses, and discloses PHI. Refer to the Legal, Security, and Privacy Practices section of our website for more information.

Mental Health Parity

Federal and state laws require that we provide behavioral health (mental health and/or substance use disorder) services to our members in the same way we provide physical health services. We refer to these laws as "parity." It means that:

- We will give members the same level of benefits and charge the same co-payments, co-insurance and deductibles for mental health and substance use disorder needs as for physical needs.
- We have similar prior authorization (permission) requirements and treatment limitations for mental health and substance use disorder services and physical health services.
- We will provide you or your member with the medical necessity criteria that we use for prior authorization upon you or your member's request.
- We will give the member the reason for any denial of authorization for mental health or substance use disorder services within a reasonable time frame.

Member Appeals and Grievances

Members have the right to file a complaint if they have concerns or problems related to their coverage or care. Appeals and grievances are two different types of member complaints. CMS defines appeals and grievances in the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. For Tufts Health Plan SCO, additional guidance is located in the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans.

Tufts Health Plan and its contracting providers must not treat members unfairly or discriminate against them because they initiate a complaint. Refer to the Member Appeals and Grievances chapter for more information on member appeals.

PUBLICATION HISTORY

03/12/24	administrative edits to Health Risk Assessment
02/25/25	added Billing Members: Qualified Medicare Beneficiary (QMB) Members section; administrative edits
01/01/26	minor language and link updates
04/01/26	added to Billing Members section: Collecting Payment, Prohibition of Balance Billing for Covered Services, and Billing Members for Non-covered services; other administrative edits
10/01/26	update for consistent use of term, “care plan”