Community Blue Medicare HMO Additional Information

Eligibility and Restrictions

Anyone who is entitled to Medicare Part A benefits and enrolled in Medicare Part B is eligible to enroll in a Medicare Advantage plan. However, if you are already enrolled in a Medicare Advantage plan such as an HMO or PPO and then enroll in a Community Blue Medicare HMO plan, you will be disenrolled from your Medicare Advantage plan. You must also live in the Community Blue Medicare HMO service area and not be enrolled in any other Medicare approved prescription drug plan. Individuals with Medicare may enroll in a prescription drug plan during specific times of the year.

As a member of our plan, you can choose to receive care from out-of-network providers.
Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, contact:

- 1-800-MEDICARE (1-800-633-4227) 24 hours a day, seven days a week. TTY/TDD users call 1-877-486-2048, www.medicare.gov on the Web.
- The Social Security Administration at 1-800-772-1213 (TTY/TDD users call 1-800-325-0778), between 7 a.m. and 7 p.m., Monday through Friday, www.socialsecurity.gov on the Web.
- Your state Medicaid office

Potential for Contract Termination

All Medicare Advantage Plan Sponsors agree to offer the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a sponsor decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for choosing other Medicare Advantage and Medicare prescription drug coverage in your area.

Disenrollment Rights and Instructions

Voluntary Disenrollment

During the Annual Election Period (October 15 through December 7), anyone with Medicare will have an opportunity to switch from one way of getting Medicare to another.

Generally, you cannot make any other changes except in certain situations, such as if you move out of your plan's service area, want to join a plan in your area with a 5-star rating, or qualify for (or lose) Extra Help paying for prescription drug costs. If you wish to leave Community Blue Medicare HMO, you will need to submit a written and signed disenrollment request to Community Blue Medicare HMO. You may also call 1-800-MEDICARE. Medicare Customer Service Representatives are available 24 hours a day, seven days a week. TTY/TDD users should call 1-877-486-2048. Until your disenrollment is effective, you must continue getting your health care through Community Blue Medicare HMO.

Involuntary Disenrollment

Community Blue Medicare HMO may end your coverage for any of the following reasons:

- You lose your entitlement to Medicare Part A hospital insurance and / or fail to pay your Medicare Part B medical insurance
- Community Blue Medicare HMO is no longer contracting with Medicare or leaves your service area
- You permanently move out of the Community Blue Medicare HMO service area and do not voluntarily disenroll
- You fail to pay your Community Blue Medicare HMO premium
- You engage in disruptive behavior, provided fraudulent information when you enrolled or knowingly permitted abuse or misuse of your enrollment card
- A change in residence (including incarceration) makes the individual ineligible to remain enrolled in the plan
- You fail to pay your Part D-IRMAA to the government and CMS notifies the Plan to effectuate the disenrollment
- You are not lawfully present in the United States

Please consult the Community Blue Medicare HMO Evidence of Coverage for complete information on disenrollment rights.

Organization Determination, Coverage Determination, Appeals and Grievances

Organization Determination

As a member of Community Blue Medicare HMO, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) organization determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

Coverage Determination

As a member of Community Blue Medicare HMO, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

Appeals and Grievances

Members of Community Blue Medicare HMO, their physicians, or authorized representatives acting on the member's behalf may request an appeal of an adverse organization determination or coverage determination made by Community Blue Medicare HMO. Examples of reasons an appeal may be filed include: the member believes he or she was denied benefits that the member is entitled to receive, the member believes there has been a delay in providing or approving the drug coverage, or the member disagrees with the amount of cost sharing he or she is required to pay.

A request for a Standard Appeal may be made orally or in writing to Community Blue Medicare PPO.

Community Blue Medicare HMO is required to notify the member in writing of its decision as quickly as the member's health condition requires, but no later than 30 calendar days for an appeal regarding services you have not received yet, 60 calendar days for an appeal for services you have received, 7 calendar days for a prescription drug appeal for a prescription drug appeal regarding a drug not yet received, and 14 calendar days for a drug appeal for services you have received from the date Community Blue Medicare HMO receives the request for the Standard Appeal.

Members of Community Blue Medicare HMO and their prescribing physicians may request that an appeal be Expedited for situations in which applying the Standard Appeal process may seriously jeopardize the member's health, life or ability to regain maximum function. (This would not include requests for payment of drugs already furnished.) A request for an Expedited Appeal can be made orally or in writing. Community Blue Medicare HMO is required to notify the member and the prescribing physician of its decision as quickly as the member's health condition requires, but no later than 72 hours after receiving the request.

Members of Community Blue Medicare HMO may file a Grievance, either orally or in writing, expressing dissatisfaction with the operations, activities or behavior of Community Blue Medicare HMO or with the quality of care or service received from a Community Blue Medicare HMO provider. Community Blue Medicare HMO is required to respond to the member's Grievance as quickly as the case requires, but no later than 30 days after the date Community Blue Medicare HMO receives the oral or written Grievance.

If you are making a grievance because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” grievance. If you have a “fast” grievance, it means we will give you an answer within 24 hours.

Please refer to the Community Blue Medicare HMO Evidence of Coverage for details on the Appeals and Grievance process.

You may request a Coverage Decision, Appeal, or Grievance by:

- Calling 1-888-757-2946, TTY users call 711, seven days a week from 8:00 a.m. to 8:00 p.m.
- Writing to P.O. Box 535047, Pittsburgh, PA 15253;
- Faxing 1-717-635- 4209

Obtaining Data on Exceptions, Appeals and Grievances

Members of Community Blue Medicare HMO can receive a description of the number of Exceptions, Appeals and Grievances received and how these cases were resolved by contacting Community Blue Medicare HMO:

- Phone member service at 1-888-757-2946, TTY users call 711, seven days a week from 8:00 a.m. to 8:00 p.m.
- Writing to P.O. Box 535047, Pittsburgh, PA 15253;
- Faxing 1-717-635- 4209

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