Your Rights and Protections as a Member of Blue Medicare Advantage (HMO)

Information about Organization & Coverage Determinations, Appeals and Grievances, Exceptions

You may refer to Chapter 9 of your *Evidence of Coverage* (EOC) for more information on any of these topics. You received a copy of the EOC when you joined your Blue Medicare Advantage (HMO) plan, and you can also find it on this website. Our Customer Service Department can be reached by calling 1-866-508-7140 (TTY: 711).

COVERAGE DECISIONS & APPEALS

An organizational coverage decision is a decision Blue Medicare Advantage makes about your benefits and coverage or about the amount we will pay for your medical services or drugs. You may ask for medical care and prescription drug coverage by contacting our Customer Service Department. Requests for reimbursement for services or drugs you have already received and paid for must be submitted in writing. We use the "standard" deadline for our decisions, unless we have agreed to use the "fast" deadlines. You can ask for a "fast" initial decision if your request for medical care or Part D drug benefits needs to be decided more quickly than within the standard time frame.

Initial Request for Service or Benefit	Standard Decision Deadline	Fast Decision Deadline
Medical Request	Up to 14 days after receipt	Within 72 hours after receipt
Medical Care Already Received	Up to 60 days after receipt	N/A
Drug Covered by Part B or Part D	Up to 72 hours after receipt	Within 24 hours after receipt
Part D Drug Already Received	Up to 14 days after receipt	N/A

If you disagree with our coverage decision, you can make an appeal, asking us to review our decision. We will decide whether to stay with our original decision or change this decision and give you some or all of the care, benefit or payment you request. Your appeal request must be made within 60 days of the initial decision.

You can ask for a "fast appeal" if your request for medical care or Part D drug benefits needs to be decided more quickly than within the standard time frame.

Appeal Type	Must be Filed By	Your Filing Deadline	Our Decision Deadline
Standard - Medical Care Request	Mail or Fax	Within 60 days of initial decision	Up to 30 days after receipt
Standard - Medical Care Already Received	Mail or Fax	Within 60 days of initial decision	Up to 60 days after receipt
Standard - Drug Covered by Part B or Part D	Mail or Fax	Within 60 days of initial decision	Up to 7 days after receipt
Fast - Medical Care Request or Drug Covered by Part B or Part D	Phone, Mail or Fax	Within 60 days of initial decision	Up to 72 hours after receipt

You may submit your appeal online or by mail, fax or phone to:

Standard Appeal

Mail: Blue Medicare Advantage
Attn: Appeals
PO Box 7065
Troy, MI 48007

Fax: 1-877-549-1748

Fast Appeal

Phone: 1-866-508-7140

If we deny your appeal request, an Independent Review Organization will review your request for medical care (Part C) and Part B benefits. You may ask for an independent review of a Part D drug benefit decision.

Part C Medical and Part B Drugs:	MAXIMUS Federal Services, Inc. Medicare Managed Care & PACE 3750 Monroe Ave., Suite 702 Pittsford, NY 14534-1302	**Part D Drug:** MAXIMUS Federal Services, Inc. Part D QIC 3750 Monroe Ave., Ste #703 Pittsford, NY 14534-1302

If you are unhappy with the decision made by the Independent Review Organization and the dollar value of appeal meets a minimum level, you may be able to ask for an Administrative Law Judge to consider your case. Additional reviews may be available by the Medicare Appeals Council and the Federal District Court.

ASKING FOR AN EXCEPTION TO THE DRUG FORMULARY

You can ask for an exception to the coverage rules of our drug formulary on the “Medicare Prescription Drug Coverage Determination Request Form.” This form is available online. You can complete and submit the form online, or you can download the form and mail it to the address on the form. You can also mail or fax a request to the address or fax number specified on the Medicare Prescription Drug Coverage Determination Request Form.

Generally, Blue Medicare Advantage will only approve your request for an exception if the alternative drug(s) included on the plan’s formulary or the lower-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

DISCHARGED FROM A HOSPITAL TOO SOON

The day you leave the hospital is called your “discharge date.” Our plan’s coverage of your hospital stay ends on this date. If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. If you want to appeal, you must contact the Quality Improvement Organization (QIO) no later than your planned discharge date and before you leave the hospital.

If you think you are being discharged too soon and want to have your discharge reviewed, you must contact the QIO:

Mail: Livanta BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701

Phone: 1-888-755-5580 (TTY: 1-888-985-9295)
Fax: 1-833-868-4061

TERMINATION OF SERVICES (SNF, CORF, HHA)

If we decide to end coverage for your Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), Home Health Agency (HHA) services, you will receive a written advance notice called the "Notice of Medicare Non-Coverage" (NOMNC) either from us or your provider at least two calendar days before your coverage ends. You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the QIO to do an independent review of whether our terminating your coverage is medically appropriate. Use the contact information shown above to reach the QIO.

MAKING COMPLAINTS (GRIEVANCES)

We are always working to improve the quality of service and care that our members receive. If you have any concerns or dissatisfaction with the plan, you have the right to file a complaint, which is also called a grievance. This could include problems related to quality of care from our providers, wait times at providers' offices, or the customer service you receive. If your dissatisfaction is with a coverage or payment decision, this is handled through the appeals process as discussed above.

Your grievance must be submitted within 60 days of the event or incident. You may contact our Customer Service Department to express your grievance. If you prefer, you may send your grievance in writing to:

Mail: Blue Medicare Advantage
Attn: Grievances
PO Box 7065
Troy, MI 48007

Phone: 1-866-508-7140

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

CUSTOMER SERVICE

Blue Medicare Advantage wants to be your partner in good health. In this role, we are always working to improve the quality of care and service that our members receive. For more information about any of these topics, please refer to your *Evidence of Coverage*, available on this website or by calling customer service at 1-866-508-7140 (TTY: 711), 8 a.m. to 8 p.m., seven days a week.