The process for coverage decisions and appeals is for problems related to your benefits and coverage for prescription drugs, including problems about payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered. The process for complaints deals with problems about quality of care, waiting times, and customer service. For more information about coverage decisions, appeals and complaints/grievances, see Chapter 7 of your Evidence of Coverage.

COVERAGE DECISIONS

What is a coverage decision?

A coverage decision is a decision we make about the coverage of or the amount we will pay for your prescription drugs. This includes asking our plan to make an exception to how we cover a drug.

How do I request a coverage decision?

Start by calling, writing, or faxing us to make your request. (See the back page of this brochure for contact information.) Include your name, address, Member ID Number, the reason for your request, and any additional information/evidence you wish to provide. You, your representative, or your doctor (or other prescriber) can do this.

If your health requires a quick response, you must ask us to make a “fast decision” when you call. When a “fast decision” is requested, you will get an answer within 24 hours (or less if your health requires us to do so). To ask for a “fast decision”, you must be asking for coverage for a drug you have not yet received and using the standard timeline for a decision could cause serious harm to your health or hurt your ability to function. If your doctor or prescriber tells us your health requires a “fast decision”, we will automatically give you a fast decision.

If you do not ask for a “fast decision”, we will use the standard decision timeline. With a standard decision, we will give you an answer within 72 hours if your request is about a drug you have not yet bought and within 14 calendar days if it is about a drug you have already bought. If you made a payment request and we agree with your request, we must make payment to you within 30 calendar days.

In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

How do I request an exception for a drug?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision and the above timelines apply. Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception before we will consider your request.

You or your doctor or other prescriber can ask us to make any of the following exceptions:

- **Covering a Part D drug for you that is not on our List of Covered Drugs (Formulary).** If we agree to make an exception and cover a drug that is not on the Formulary, you will need to pay the cost-sharing amount that applies to the Non-Preferred Brand tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug. Excluded drugs cannot be covered.

- **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our Formulary. For example, you may ask us to waive the quantity limit for a certain drug.

- **Changing coverage of your drug to a lower cost-sharing tier.** Every drug on our Formulary is in one of several cost-sharing tiers. In general,
the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug. If your drug is in the Non-Preferred Brand tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand tier. This would lower your share of the cost for the drug. You cannot ask us to change the cost-sharing tier for any drug in the Specialty tier. (NOTE: Plans with a single cost-share (i.e., 25% coinsurance) for all drug tiers would not benefit from this type of exception. This exception is not applicable to those plans. Please see Chapter 4 of your Evidence of Coverage for your cost-sharing amounts.)

Our plan is not required to grant any of these exception requests.

**What if I disagree with your decision?**

If you disagree with a coverage decision we make, you can appeal our decision. There are several levels of appeal, described below.

**APPEALS**

**What is an appeal?**

If we make a coverage decision and you are not satisfied with this decision, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. This includes a decision to deny coverage or payment for prescription drugs you have already received and paid for.

**How do I appeal a decision?**

You have up to 60 calendar days to file your appeal, but it is best to file your appeal as soon as you decide you disagree with the decision our plan has made. We may give you more time if you have a good reason for missing this deadline. Start by calling, writing, or faxing us to make your request. *(See the back page of this brochure for contact information.)* Include your name, address, Member ID Number, the reason for your request, and any additional information/evidence you wish to provide. You, your representative, or your doctor (or other prescriber) can do this.

You may request a “fast appeal” in writing or over the phone if you are appealing a decision we made about a drug you have not yet received and using the standard timeline for an appeal could cause serious harm to your health or hurt your ability to function. If you request a “fast appeal”, you will receive a decision from us within 72 hours of receipt of the appeal.

If you do not request a “fast appeal”, we will use the standard appeal timeline and you will receive a response from us within 7 calendar days. We do not accept standard appeals by phone.

**What happens when I make an appeal?**

When you make an appeal, we review the coverage decision we made to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision in writing.

**What if I disagree with your decision about my first appeal?**

If our plan says no to your appeal, we will send you a written explanation of our decision along with instructions on how to make a Level 2 Appeal. You choose whether to accept our decision or continue by making another appeal. If you decide to make another appeal, your appeal will go on to Level 2 of the appeals process where our decision will be reviewed by the Independent Review Organization. This organization is not connected with us in any way and decides whether our decision should be changed or not. To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case. When you make a Level 2 Appeal, we will send the information we have to the Independent Review Organization.

If your health requires it, you can ask the Independent Review Organization for a “fast appeal”. If the organization agrees to a “fast appeal”, they must give you an answer within 72 hours after they receive your appeal. If the organization says yes to all or part of what you requested in your appeal, we must provide the drug coverage that was approved within 24 hours. If you have a standard appeal, the organization must give you an answer within 7 calendar days after they receive it. If the organization says yes to all or part of what you requested in your appeal, we must provide the drug coverage within 72 hours. If a
payment request for a drug you have already paid for is approved by the organization, we must send you payment within 14 calendar days.

**How many appeals can I make?**

If you disagree with the Level 2 Appeal decision you can continue to Level 3, but the dollar value of the drug coverage you are requesting must meet a minimum amount. The notice you get following your Level 2 Appeal will tell you if your appeal meets that dollar amount. If the dollar amount of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.

If your appeal qualifies for Level 3, an Administrative Law Judge will review your appeal and give you an answer. If the judge says no to your appeal, the notice you will get tells you what to do next if you choose to continue with your appeal. At Level 4, the Medicare Appeals Council, who works for the federal government, will review your appeal and give you an answer. If you disagree with the Level 4 decision, you may be able to continue to the next level of appeal. At Level 5, a judge at the Federal District Court will review your appeal. This is the last step of the appeals process.

**COMPLAINTS/GRIEVANCES**

**What is a complaint/grievance?**

The formal name for making a complaint is “filing a grievance”. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times (including those for coverage decision or appeals responses), and the customer service you receive.

We encourage you to let us know right away if you have questions, concerns or problems related to your prescription drug coverage. You cannot be disenrolled or penalized for making a complaint.

**How do I make a complaint?**

Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know.

If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing. We will respond to your complaint in writing. (See the back page of this brochure for contact information.)

**What happens when I make a complaint?**

Whether you choose to call or write, you should contact Member Services right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about. If you are making a complaint because we denied your request for a “fast decision” about a coverage decision or appeal, we will automatically give you a “fast complaint” and give you an answer within 24 hours.

Whenever possible, we will answer you right away. Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 days total) to answer your complaint. If we do not agree with all or part of your complaint or don’t take responsibility for the problem you are complaining about, our response will include our reasons. Our plan must respond whether we agree with your complaint or not.

**What if my complaint is about quality of care?**

When your complaint is about quality of care, you can make your complaint by using the process outlined above. You also have two extra options.

- You can make your complaint to the Quality Improvement Organization. If you prefer, you can make your complaint directly to this organization without making a complaint to us.
- Or, you can make your complaint to both at the same time.

To find the name and contact information for the Quality Improvement Organization for your state, see Chapter 2, Section 4, of your Evidence of Coverage.
For Member Services:
Call: 1-877-MedRxHelp (1-877-633-7943)  
24 hours a day, 365 days a year
TTY: 711
Write: Medicare GenerationRx  
P.O. Box 509099  
San Diego, CA 92150

For Coverage Decisions:
Call: 1-877-MedRxHelp (1-877-633-7943)  
24 hours a day, 365 days a year
TTY: 711
Fax: 1-858-790-7100
Write: Attn: Prior Authorization Department  
MedImpact Healthcare Systems, Inc.  
10680 Treena Street, Stop 5  
San Diego, CA 92131

For Appeals:
Call: 1-877-MedRxHelp (1-877-633-7943)  
24 hours a day, 365 days a year (for expedited or fast appeals).  
Please note: We do not accept standard appeals by telephone call. Standard appeals must be submitted in writing.
TTY: 711
Fax: 1-858-790-6060
Write: Attn: Appeals Department  
Medicare GenerationRx  
P.O. Box 509099  
San Diego, CA 92150

For Complaints/Grievances:
Call: 1-877-MedRxHelp (1-877-633-7943)  
24 hours a day, 365 days a year
Fax: 1-858-790-6000
TTY: 711
Write: Attn: Grievance Department  
Medicare GenerationRx  
P.O. Box 509099  
San Diego, CA 92150