

## Coverage Determinations

### Contact Information

CALL 1-800-645-3965

TTY/TDD: 1-888-857-4816

WRITE: Medicare Member Appeals Unit, P.O. Box 41820, Philadelphia, PA 19101-1820

VISIT: 1901 Market Street, 1st Floor, Philadelphia, PA 19103

FAX: 1-888-289-3008

## **Coverage Determinations: Our Plan makes a coverage determination about your Part D prescription drug, or about paying for a Part D drug you have already received.**

### **What is a coverage determination?**

The coverage determination made by our Plan is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered you should contact our Plan and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request (this is sometimes called an “adverse coverage determination”), you can “appeal” our decision by going on to Appeal Level 1. If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review.

The following are examples of coverage determinations:

- You ask us to pay for a drug you have already received. This is a request for a coverage determination about payment. You can call Customer Service to get help in making this request.
- You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can refer to our Customer Service to ask for this type of decision.
- You ask for an exception to our plan's utilization management tools. Requesting an exception to a utilization management tool is a type of formulary exception. You can call Customer Service to ask for this type of decision.
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can refer to our Customer Service to ask for this type of decision.
- You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a doctor's office, will be covered by the plan. You can refer to our Customer Service to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a doctor's office.

**When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of our Plan apply to your specific situation.**

### **Who may ask for a coverage determination?**

You can ask us for a coverage determination yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. You can call Customer Service to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

### ***Asking for a "Standard" or "Fast" Coverage Determination***

#### ***Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?***

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

#### **Asking for a standard decision**

To ask for a standard decision, you, your doctor, or your appointed representative should refer to our Customer Service numbers. Or, you can deliver a written request to Medicare Member Appeals Unit, P.O. Box 41820, Philadelphia, PA 19101-1820, or fax it to 1-888-289-3008.

## Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling our Customer Service numbers. Or, you can deliver a written request to Medicare Member Appeals Unit, P.O. Box 41820, Philadelphia, PA 19101-1820, or fax it to 1-888-289-3008. Be sure to ask for a “fast,” “expedited,” or “24-hour” review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “grievance” if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard timeframe.

## What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.*  
Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as dosage or quantity limits or step therapy requirements), we must make our decision no later than 72 hours after we have received your doctor's "supporting statement," which explains why the drug you are asking for is medically necessary.  
**If you are requesting an exception, you should submit your prescribing doctor's supporting statement with the request, if possible.**

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision.

If we have not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. *For a fast coverage determination about a Part D drug that you have not received.*

If you get a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review -- sooner if your health requires. If your request involves a request for an exception, we must make our decision no later than 24 hours after we get your doctor's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision, under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision.

If we decide you are eligible for a fast review, and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your doctor's request for a fast review, we will give you our decision within the standard 72- hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

### **What happens if we decide completely in your favor?**

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we get your doctor's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we get the request.

2. *For a fast decision about a Part D drug that you have not received.*

We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we get your doctor's "supporting statement."

### **What happens if we deny your request?**

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested.

If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision.