Part D Prescription Drugs – Coverage Determinations (including Exceptions), Appeals, Grievances

The section provides a brief summary of your rights to request coverage of prescription drug that you have purchased. You also may make a complaint about your prescription drug benefits and coverage. Chapter 9 of your Evidence of Coverage explains the grievance and appeals rights and procedures in more detail.

Introduction

When we make a coverage determination, we are making a decision about whether to provide or pay for a Part D drug and what your share of the cost is for the drug (coverage determinations include exceptions requests). The following are examples of coverage determinations:

- You ask for an exception to our utilization management tools, such as prior authorization, dosage limits, quantity limits, or step therapy requirements. These are types of "formulary exceptions.
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a tiering exception.
- You ask us to pay for a prescription drug you already bought. This is a request for coverage determination about payment.

Types of Coverage Determinations That You Can Request

1. Fast (24 hours) - You can request a fast coverage determination only if using the standard deadlines could cause serious harm to your health or hurt your ability to function. If your doctor or other prescriber asks for a fast determination for you, or supports you in asking for one, and the doctor or other prescriber indicates that waiting for a standard determination could seriously harm your health or your ability to function; we automatically will give you a fast determination. If you ask for a fast coverage determination without support from a doctor or other prescriber, we will decide if your health requires a fast determination.

2. Standard coverage decision about a drug you have not yet received (72 hours) - Any request for a Part D drug that you have not yet purchased and that does not need to be decided within 24 hours for protection of your health or ability to function will be decided as a standard determination.

3. Standard coverage decision about payment for a drug you have already bought (14 calendar days) – Any request for payment for a Part D drug you have already purchased will be decided as a standard determination.

Exception

An exception is a type of coverage determination. Whenever you request an exception, your doctor or other prescriber must submit a statement and supporting information about the medical need for the exception. A request for an exception will be approved only when there is a medical reason for it. A Medicare Part D Coverage Determination Request Form is available on our website, although using the form is not required. You have the right to ask us for an "exception" if you want us to:

- waive coverage restrictions on your drug (quantity limits, prior authorization, or step therapy)
- provide a higher level of coverage, which means a lower co-payment for your drug.

You can ask us to make the following exceptions to our coverage rules for Part D prescription drugs:

Formulary Exception

You can make a request for an exception for drugs that have coverage restrictions, including quantity limits, step therapy requirements, and prior authorization. If the exception is approved, arrangements will be made to cover the drug for up to one year from the approval date, up to your pharmacy benefit limit, and you will be notified of the approval. Quantity limit exception request approvals are up to five years. If

the exception is denied, you will be notified of the decision and given information about your appeal rights.

Tiering Exception
You can ask us to provide a higher level of coverage for your drug. If the exception is approved, arrangements will be made to cover the requested drug at the lower tier copayment for up to one year from the approval date, up to your pharmacy benefit limit, and you will be notified of the approval. If the exception is denied, you will be notified of the decision and given information about your appeal rights.

PrimeTime Health Plan will notify you and your doctor or other prescriber of our decision about a standard request for an exception as quickly as your health condition requires, but no later than 72 hours after we receive the required information from your doctor or other prescriber. Our notification will be given within 24 hours after we receive the required information from your doctor or other prescriber if he or she indicates that waiting for a standard determination could seriously harm your health or your ability to function. If your doctor or other prescriber does not provide us with the required information, we will follow up with the doctor to obtain the documentation to support your request. If your doctor or other prescriber still does not provide the requested information, we will make our decision with the information that we have.

To ask for a coverage determination, including an exception, you, your authorized representative, or your doctor may call, write, or fax your request. If your health requires it, ask us to give you a fast decision. You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

Telephone: 330-363-7407 or toll-free 1-800-577-5084 (TTY users should call 711)
Fax: 330-580-6764
Mail: PrimeTime Health Plan, Attn: Pharmacy Department, PO Box 6905, Canton, Ohio 44706

Appeals
If we deny your request, we will send you a written decision explaining the reason(s). Please consult Chapter 9 of your Evidence of Coverage for more detailed information on prescription drug benefits/coverage appeals.

If we deny part of or your entire request in our coverage determination, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination." Please call us if you need help with filing your appeal. You must appeal our denial within 60 calendar days of the date on the notice of our coverage determination. (We can give you more time if you have a good reason for missing the deadline.)

You may ask us to reconsider our coverage determination even if only part of our decision is not what you requested. If your appeal concerns a decision that we made about authorizing a Part D benefit that you have not received yet, you and/or your doctor or other prescriber first will need to decide whether you need a fast appeal. The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you, your doctor or other prescriber, or your appointed representative may file the request. The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination.

There are Two Kinds of Appeals That You Can Request

Expedited (72 hours) - You can request an expedited (fast) appeal for cases that involve coverage if you or your doctor or other prescriber believe that your health could seriously be harmed by waiting up to 7 days for a decision. If your request to expedite is granted, you will receive a decision no later than 72 hours after your appeal is received.

If the doctor or other prescriber who prescribed the drug(s) asks for an expedited appeal for you, or support you in asking for one, and he or she indicates that waiting for 7 days could seriously harm your health, the appeal automatically will be expedited.

If you ask for an expedited appeal without support from a doctor or other prescriber, we will decide whether your health requires an expedited appeal. If you do not get an expedited appeal, your appeal will be decided within 7 days.

Your appeal will not be expedited if you already have received the drug that you are appealing.

Standard (7 days) - You can request a standard appeal for a case that involves coverage or payment. You will receive a decision no later than 7 days after your appeal is received.

What Do I Include with My Appeal?
You should include your name, address, Member ID number, the reasons for appealing, and any evidence that you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (formulary), your doctor or other prescriber must indicate that all of the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

What Happens Next?
If you appeal, we will review our decision. If we continue to deny the Part D drug or exception request, you may ask for a review by a government-contracted independent review organization. The denial letter will tell you how to start this outside appeal. If you disagree with the decision of the outside reviewer, you will have further appeal rights. You will be notified of those appeal rights if this happens. Physicians and/or prescribers are able to request a review with the independent review organization on your behalf without completing an appointment of representative form. The physician and/or prescriber must notify you when they make a review request on your behalf. The independent review organization is responsible for notifying the physician and other prescribers of its decision when the physician and/or prescribers make the request on your behalf.

Grievance
A "grievance" is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with PrimeTime Health Plan's Medicare program or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by telephone or get the information that you need, or the cleanliness or condition of a network pharmacy.

There are Two Kinds of Grievances That You Can Request:

Fast (24 hours) - If you disagree with our decision not to give you a fast decision on prescription drug coverage. We must respond to this type of grievance within 24 hours of the time that we receive it.

Standard (30 days) - Any other type of complaint. We must respond to this type of grievance as promptly as your medical condition requires, but no later than 30 calendar days from the date that we receive it.

How Do I Submit a Grievance?
You or your appointed representative may call Member Services or you may write to us. If you submit a written grievance, you will get an answer in writing. If you submit a verbal grievance, you will get an answer by telephone or in writing. All quality of care grievances will be answered in writing.

For an Expedited Grievance: You or your appointed representative should contact us by telephone or fax at the numbers below:

Telephone: 330-363-7407 or toll-free 1-800-577-5084 (TTY users should call 711)

Fax: 330-363-3066

For a Standard Grievance: You or your appointed representative should call, mail, or deliver your grievance request to the address/number below:

Mail: PrimeTime Health Plan, Attention: Grievance & Appeals, P.O. Box 6029 Canton, Ohio 44706

Telephone: 330-363-7407 or toll free 1-800-577-5084 (TTY users should call 711)

Contact Information
If you need information on the status of your coverage determination, appeal, or grievance, or would like to obtain an aggregate number of grievances and appeals filed with this plan, call us at: 330-363-7407 or toll-free 1-800-577-5084 (TTY users should call 711). Our Call Center hours are Monday through Friday from 8 a.m. to 8 p.m. (October 1 – March 31, we are available 7 days a week, 8 a.m. to 8 p.m.).