



## **Grievance, Exceptions, Coverage Determinations and Appeals Procedures for Network Platinum Medicare Advantage Plans Part D Prescription Drug Benefits**

### **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 a Network Platinum Medicare Advantage Plan 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 with things such as:

- waiting times when you file a prescription
- the way your network pharmacist or others behave
- not being able to reach someone by phone or get the information you need
- the cleanliness or condition of a network pharmacy

If you have a grievance we encourage you to first call Customer Service at the number listed in your Evidence of Coverage. We will try and resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this our Grievance and Appeal process. A representative will fully investigate your concern, including all aspects of clinical care. To use the formal grievance process, send your grievance in writing to the Customer Service Department at the address found in your Evidence of Coverage. If you request a fast coverage determination or appeal and we deny your request, we will contact you orally and send you a letter within 72 hours notifying you that your request will automatically follow our standard grievance and appeals process. In addition, you will be notified of your right to file an expedited grievance if you disagree with Network Platinum Medicare Advantage Plan's decision not to expedite the reconsideration.

### **Exceptions**

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make, such as:

- Asking us to cover your drug even if it is not on our formulary
- Asking us to waive coverage restrictions or limits on your drug
- Asking us to provide a higher level of coverage for your drug

If you request an exception, your physician must provide a statement to support your request. Generally, we will only approve your request for an exception if the alternative drugs included in the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

If we approve your exception request, our approval is valid for the remainder of the plan year, as long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision.

## Coverage Determination

Whenever you ask for a Part D prescription drug benefit, the first step is called “requesting a coverage determination.” When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. You must contact us if you would like to request a coverage determination. You cannot request an appeal if we have not issued a coverage determination.

There are two types of coverage determinations: standard or fast. A decision about whether we will cover a Part D prescription drug can be a standard coverage determination. This is made within the standard time frame, typically within 72 hours. You can only request a fast decision if you or your doctor believes 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. For a fast decision we will give you our decision within 24 hours or sooner if your health requires.

## Appeal

If you are unhappy with the coverage determination, you can ask for an appeal. You may also appeal our decision:

- Not to cover a drug, vaccine or other Part D benefit
- Not to reimburse you for a Part D drug that you paid for
- If you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay
- If we deny your exception request

You must file your appeal in writing within 60 calendar days after the date of the denial. We can give you more time if you have a good reason for missing the deadline.

## There are two kinds of appeals:

### Standard Appeal

If your request is about reimbursement for a **Part D drug you already paid for and received or about a Part D drug you have not received** you can ask for a standard appeal. We must give you a decision within 7 calendar days, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will automatically go to the second level of appeal, where an independent organization will review your case.

### Fast Appeal

You can ask for a fast appeal if you or your doctor believe that **your health could be seriously harmed by waiting too long for a decision**. We must decide on a fast appeal no later than 72 hours after we get your appeal, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If any doctor asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 7 calendar days could seriously harm your health, we will automatically give you a fast appeal. If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within 7 calendar days.

If we deny any part of your appeal, you or your appointed representative have the right to ask for an independent review organization to review your case. This independent review organization contracts with the Federal government and is not part of a Network Platinum Medicare Advantage Plan. You must make your request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the independent review organization whose name and address is included in the Level 1 re-determination.