Coverage Determinations

When you ask for a decision on your Part D prescription drug benefit, you are requesting a Coverage Determination.

If your health care provider or pharmacist tells you that we will not cover a prescription drug, or if you are charged more than you think your copayment or coinsurance should be, you or your provider may ask us or a Coverage Determination. The following are examples of when you can ask us for a Coverage Determination:

- If there is a limit on the quantity (or dose) of a drug and you disagree with the limit
- If there is a requirement that you try another drug before we will pay for the drug you are asking for
- If the copayment for a drug is higher than expected
- If the drug is listed as non-formulary

When you request a Coverage Determination, you will receive a response from us within:

- 72 hours for a "standard" decision
- 24 hours, if you have asked for a "fast" decision, also called an expedited determination

The process for requesting a Coverage Determination is discussed in more detail in Chapter 7 of your ***Evidence of Coverage,*** *"What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."*

If you or your provider do not agree with the outcome of the initial Coverage Determination, you or your provider may appeal the decision by requesting a Coverage Redetermination. This is also called a Level 1 Appeal.

Part D Appeals

You can file an Appeal if you do not agree with our Coverage Determination. You must make your Appeal request within 60 calendar days from the date on the written notice we send to answer your request for a Coverage Determination. If you miss this deadline and have a good reason for missing it, we may give you more time to make your Appeal.

You will receive a response from us on a Level 1 Appeal within:

- 7 calendar days for a "standard" decision
- 72 hours, if you have asked for a "fast" decision

If our Plan says no to your Level 1 Appeal, the written notice we send you will include instructions on how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

You will receive a response on a Level 2 Appeal from the Independent Review Organization within:

- 7 calendar days for a "standard" decision
- 72 hours, if you have asked for a "fast" decision

If the Independent Review Organization says no to your Appeal, you may be able to continue to a 3rd level Appeal with an Administrative Law Judge (ALJ). The dollar value of the coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another Appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the Appeals process.

If the ALJ denies your Appeal, then your case may be reviewed by the Medicare Appeals Council (MAC). If your case is reviewed and denied by the MAC, then the notice you get will tell you whether the rules allow you to go on to the 5th and final level of Appeal. If the rules allow you to go on, the written notice will tell you who to contact and what to do next if you choose to continue with your Appeal. The 5th level Appeal is reviewed by a judge at the Federal District Court. This is the last stage of the administrative Appeals process.

You, your prescribing health care provider, or another person you name can file an Appeal for you. The person you name would be your appointed representative. If you want some other person to act for you, you and that person must sign and date a statement that gives that person legal permission to act as your appointed representative.