Part D Coverage/Organization Determination and Appeals Process (Prescription)

Part D Coverage Decisions

Your benefits as a member of our plan includes coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Here are examples of coverage decisions you ask us to make about your Part D drugs.

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary).*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get).
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with the coverage decision we have made you can appeal our decision.

PART D EXCEPTIONS

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. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

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1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)
   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 - Non-Preferred Brand Drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)*

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.

- If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five 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 our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
     - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
     - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
   - You cannot ask us to change the cost-sharing tier for any drug in Tier 5.
   - If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

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IMPORTANT THINGS TO KNOW ABOUT ASKING FOR EXCEPTIONS:
Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception. Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won’t work as well for you

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

How To Ask For a Coverage Decision, Including an Exception:
If your health requires a quick response, you must ask us to make a "fast coverage decision". You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What To Do

- Request the type of coverage decision you want. Start by calling, writing or faxing our plan's Member Services Department. You, your representative or your doctor (or other prescriber) can do this.
- To make your request by phone, call 1-833-866-6559 (TTY: 1-800-955-8770). Hours are 8:00 a.m. - 8:00 p.m. local time, seven days a week from October 1 - March 31, except for Thanksgiving Day and Christmas Day. However, from April 1-September 30, our hours are 8:00 a.m. - 8:00 p.m. local time, five days a week. You will have to leave a message on Saturdays, Sundays and Federal holidays. We will return your call within one business day.

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- To make your request in writing or fax :

FHCP Medicare
Attn; Member Services
1340 Ridgewood Avenue
Holly Hill, FL 32117
Fax: 386-676-7149

- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. You can give written permission to someone else to act as your representative. You can utilize the Appointment of Representative form that gives a person legal permission to by your appointed representative. You can also have lawyer act on your behalf
- If you want to ask our plan to pay you back for a drug. Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.
- If you are requesting an exception, provide the doctor's statement. Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow-up by faxing or mailing the signed statement.
- We must accept any written request, including a request submitted to the CMS Model Coverage Determination Request Form.

Our Plan Considers Your Request and We Give You Our Answer:

Deadlines for a "fast" coverage decision:

- If we are using the fast deadlines we must give you are answer within 24 hours.
  - Generally this means within 24 hours after we received you request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process where it will be reviewed by an Independent Review Organization.
- If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we received your request or doctor's statement supporting your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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Level I Appeal

How to ask for a review of a coverage decision on a Part D Medicare covered drug made by our plan.

- You, your authorized representative, doctor or other prescriber must contact our plan.
- Make your appeal in writing by submitting a signed request To make your request in writing or by fax

FHCP Medicare
Attn: Member Services
1340 Ridgewood Avenue
Holly Hill, FL 32117
Fax: 386-676-7149

- You must make your appeal request within 60 days from the date on the written notice we sent you to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- You can ask for a copy of the information in your appeal and add more information.
    - You have the right to ask us for a copy of the information regarding you appeal. We are allowed to charge a fee for copying and sending this information to you.
    - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal“

Our plan considers your appeal and we give you our answer.

Deadlines for a "fast" appeal.

- We must give you our answer within 72 hours after we receive your appeal.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeal process, where it will be reviewed by an Independent Review Organization.
- If our answer is yes to part or all of what you requested we must provide the coverage we have agreed to provide within 72 hours.
- If our answer is no we will send you a written statement that explains why we said no and how to appeal our decision.

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Deadlines for a "Standard" appeal.

- We must give you our answer within 7 calendar days after we receive your appeal.
  - If we do not give you an answer within 7 calendar days, we are required to send your request on to Level 2 of the appeal process, where it will be reviewed by an Independent Review Organization.
- If our answer is yes to part or all of what you requested
    - If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
    - If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.
- If our answer is no we will send you a written statement that explains why we said no and how to appeal our decision.

Level 2 Appeal

To make a Level 2 Appeal you must contact the Independent Review Organization and ask for a review of your case.

For more information please refer to the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of your 2018 Evidence of Coverage.