

## Information on Coverage Determinations and Exceptions

### What is a coverage determination?

The coverage determination we make 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 us 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 prescription drug you have already received. If we deny your request (this is sometimes called an “adverse coverage determination”), you may “appeal” the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage-determination requests:

- You ask us to pay for a prescription drug you have received. This is a request for a coverage determination about payment. You may call us at 1-800-605-3256 to ask for this type of decision.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a “formulary”). This is a request for a “formulary exception.” You may call us at 1-800-605-3256 to ask for this type of decision. See “What is an Exception” below for more information about the exceptions process.
- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You may call us at 1-800-605-3256 to ask for this type of decision. See “What is an Exception” below for more information about the exceptions process.
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a “tiering exception.” You may call us at 1-800-605-3256 to ask for this type of decision. See “What is an Exception” below for more information about the exceptions process.
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician’s office, will be covered by the Plan. You may call us at 1-800-605-3256 to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician’s office.

### What is an exception?

An exception is a type of coverage determination. You may ask us to make an exception to our coverage rules in a number of situations.

- You may ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan that covers those excluded drugs.
- You may ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you may ask us to waive the limit and cover more.

- You may ask us to provide a higher level of coverage for your drug. If your drug is contained in our highest tier subject to the tiering exceptions process tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the lowest tier subject to the tiering exceptions process tier instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the Specialty Drug tier.

Generally, we will only approve your request for an exception if the alternative drugs included on the Plan formulary or the drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

**Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.**

If we approve your exception request, our approval is valid for the remainder of the Plan year, so 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 may appeal our decision.

**Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment or coinsurance amount we require you to pay for the drug.**

Who may ask for a coverage determination?

You, your prescribing physician, or someone you name may ask us for a coverage determination. The person you name would be your “appointed representative.” You may name a relative, friend, advocate, doctor, or anyone else to act for you. 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 be your appointed representative. This statement must be sent to us at Post Office Box 100191, Columbia, SC 29202-3191. To learn how to name your appointed representative, you may call Customer Service at 1-800-605-3256 (TTY: 1-888-300-7215).

You also have the right to have a lawyer act for you. You may 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 time frame?

A decision about whether we will give you or pay for a Part D prescription drug can be a “standard” coverage determination that is made within the standard time frame (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 also called an “expedited coverage determination.”

You may 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 asking us to pay you back 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 call, fax, or write us at:

Medicare Advantage  
Post Office Box 100191  
Columbia, SC 29202-3191  
1-800-605-3256 (TTY: 1-888-300-7215)  
FAX: (803) 264-9581

Outside of regular weekday business hours, please call Customer Service and leave a detailed message. Requests received outside of regularly scheduled business hours will receive priority attention the next business day.

### Asking for a fast decision

You, your doctor, or your appointed representative may ask us to give you a fast decision by calling, faxing, or writing us at:

Medicare Advantage  
Post Office Box 100191  
Columbia, SC 29202-3191  
1-800-605-3256 (TTY: 1-888-300-7215)  
FAX: (803) 264-9581

Outside of regular weekday business hours, please call Customer Service and leave a detailed message. Requests received outside of regularly scheduled business hours will receive priority attention the next business day. 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 time frame.

## What happens when you request a coverage determination?

1. For a standard coverage determination about a Part D drug that includes a request to pay you back for a Part D drug that you have already received.

Generally, we must give you our decision no later than 72 hours after we receive 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 give you our decision no later than 72 hours after we receive your physician’s “supporting statement” explaining why the drug you are asking for is medically necessary.

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

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

If we give you 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 will give you our decision no later than 24 hours after we have received your physician’s “supporting statement,” which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

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

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

1. For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug that you have already received.

We must give you the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must give you the Part D drug you requested no later than 72 hours after we receive your physician’s “supporting statement.” If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

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

We must give you the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must give you the Part D drug you requested no later than 24 hours after we receive your physician’s “supporting statement.”

## What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If a coverage determination does not give you all that you requested, you have the right to appeal the decision. (See Appeal Level 1 in “Appeals and Grievances.”)