Part D Coverage Decisions, Exceptions, Appeals & Grievances

TexanPlus® HMO, TexanPlus® HMO-POS, TexanPlus® HMO-SNP, Today's Options® PFFS, Today's Options® PPO, and Today's Options® HMO (hereinafter, the Plan) allows members to submit requests for coverage and also submit complaints, which may become either an appeal or a grievance, to the Plan.

What is a coverage decision?

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. An initial coverage decision about your Part D drugs is called a coverage determination.

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.

Generally, the Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

For more detailed information and examples of exceptions, please review your Evidence of Coverage.

How do I request an exception and an appeal to an exception?

Step 1:

Request the type of coverage decision you want.

Start by calling, writing or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process online. For more detailed information and examples of exceptions, please review your Evidence of Coverage.

Coverage Determination (initial request)

Phone:
Please call us at the on the back of your Member ID card from 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 711) 7 days a week.

Fax:
1-855-714-6218

Mail:
P.O. Box 31397
Tampa, FL 33631-3397

Online:
You can initiate a request on the plan website under the For Members, Plan Documents section, in the Prescription Drug Benefits section.

Step 2:

We consider your request and we give you our answer.

Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

If we approve your request, depending on the drug, most formulary exceptions are granted at least through the end of the plan year beginning on the date the formulary exception was originally approved.

Step 3:

If we say no to your coverage request, you decide if you want to make an appeal.

If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made. An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Level 1 Appeal Process:

Level 1, Step 1: You contact us to make a Level 1 Appeal (Redetermination).

Phone:
Please call us at the number for your plan below from 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 711) 7 days a week.

Fax:
1-855-840-7315

Mail:
P.O. Box 31383
Tampa, FL 33631-3383

Online:
You can initiate a request on the plan website under the For Members, Plan Documents section, in the Prescription Drug Benefits section.

Level 1, Step 2: We consider your appeal and we give you our answer.

We must give you our answer within seven days after we receive your request for a standard Appeal. If your health requires an answer sooner than seven days, you may ask for a fast Appeal (also called an expedited Appeal). For a fast Appeal, we must give you our answer within 72 hours after we receive your appeal (or your prescriber's supporting statement).

If we approve your request, depending on the drug, most formulary exceptions are granted at least through the end of the plan year beginning on the date the formulary exception was originally approved.

Step 4:

If we say no to your Level 1 Appeal, you decide if you want to continue with the appeals process and make *another* appeal (Level 2 Appeal).

If you decide to go on to a Level 2 Appeal, the **Independent Review Organization (MAXIMUS Federal Services)** reviews the decision we made when we said no to your first appeal. This organization decides whether the **decision we made should be changed.**

Level 2 Appeal Process:

Level 2, Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

MAXIMUS Federal Services

Phone (Member Services):
1-877-456-5302

Fax:
1-866-825-9507

Mail:
Medicare Part D QIC
3750 Monroe Avenue #703
Pittsford, NY 14534

Level 2, Step 2: The Independent review organization will make a decision.

Step 5:

If the independent Review Organization says no to your Appeal

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue to a **Level 3 Appeal**, the dollar value of the drug coverage you are requesting must meet a minimum amount. The Level 3 Appeal is handled by an administrative law judge. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process and information on how to proceed.

For more information on the Level 2 and the Level 3 process please see your Evidence of Coverage.

For an aggregate number of coverage determinations/appeals or for process or status questions, please contact us at the number on the back of your member ID card.

Please refer to your Evidence of Coverage sections on Coverage Decisions and Exceptions for more information on what to do next.

Medicare Advantage Prescription Drug (MA-PD) Plan Grievances

What is a Grievance?

A Grievance is a complaint you file for any other problem or issue with the Plan or one of our network pharmacies. You have the right to file a Grievance at any time.

How do I file a Grievance with the Plan?

If you have a Grievance or a question about Grievances, we encourage you to first call us at the number on the back of your Member ID card. We will try to resolve any complaint that you might have over the phone.

If you request a written response to your phone complaint, we will respond to you in writing. If we cannot resolve your complaint over the phone, we will resort to using a formal procedure to review your complaints. We call this the Grievance Process.

You may file a Grievance by telephone, fax, or through the mail, no later than 60 days after the event that caused the Grievance. We will respond to all written Grievances no later than 30 days from the date the Plan received the Grievance.

If your Grievance involves a refusal by the Plan to grant your request for an expedited Coverage Determination or an Expedited Redetermination, and you have not yet received the medication that is in dispute, you may file an expedited (fast) Grievance. To file an expedited Grievance, please contact us at the number on the back of your member ID card to make a request over the phone. In this case, you will receive a response within 24 hours.

You can file a Grievance or Expedited Grievance by mailing or faxing us your written complaint to:

P.O. Box 18200
Austin, TX 78760-8200
c/o Appeals and Grievances

Fax: 1-800-817-3516

Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. You will receive a letter notifying you of the extension.

Please refer to the Chapter on Grievances in your Evidence of Coverage, for more information on what to do next.

For an aggregate number of grievances or for process or status questions, please call us at the number on the back of your Member ID card.

You may also file a complaint with Medicare by calling 1-800-633-4227 (TTY users call 1-877-486-2048) 24 hours a day, 7 days a week or visit the Medicare website at www.Medicare.gov or the Ombudsman at Medicare website (www.cms.gov/Center/Special-Topic/Ombudsman-Center.html). On the Medicare site you may file a complaint using the Medicare Complaint Form (https://www.medicare.gov/medicarecomplaintform/home.aspx).

Appointing a Representative

As our member, you can appoint a caregiver or someone to act as an official representative on your behalf. We must have your written authorization signed by both you and the person you wish to designate as your Appointed Representative. An Appointment of Representative form can be found on the Plan website in the Form Members, Plan Documents section.

A representative who is appointed by the court or who is otherwise authorized under state law to act on your behalf in this regard may also file a request on your behalf, after sending us the supporting legal documentation. You will not need to complete an Appointment of Representative Form if you send supporting documentation with your request showing that another person is authorized to act on your behalf under state law.