

Important information

about appeals, grievances and exceptions for drugs covered by Medicare Part D

Appeals

An **appeal** is the type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Below is the process for filing an appeal for drugs that are covered under Medicare Part D.

There are two kinds of appeals you can request:

Expedited (72 hours)—You can request an expedited (fast) appeal if you or your doctor believes that your health could be seriously harmed by waiting up to seven days for a decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after receiving your appeal.

- **If the doctor who prescribed the drug(s)** asks for an expedited appeal for you, or supports you in asking for one, and the doctor indicates that waiting for seven days could seriously harm your health, **we will automatically expedite the appeal.**
- If you ask for an expedited appeal without support from a doctor, we will decide if your health requires an expedited appeal. If we do not give you an expedited appeal, we will decide your appeal within seven days.
- Your appeal will not be expedited if you've already received the drug you are appealing.

Standard (seven days)—You can request a standard appeal. We must give you a decision no later than seven days after we get your appeal.

What do I include with my appeal?

You should include your name, address, member ID number, reasons for appealing and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our list of covered drugs (our formulary), your prescribing physician must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How do I request an appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

For an expedited appeal: You or your appointed representative should contact us by telephone or fax at the numbers below:

1-800-868-5200 (TDD/TTY: 1-877-608-7677)
Monday through Friday, 8 a.m. to 6 p.m.
Fax: 1-508-755-7393

Or, you may contact us by e-mail at:
grievance@fchp.org

For a standard appeal: You or your appointed representative should mail or deliver your written appeal request to the address below:

Fallon Community Health Plan
Member Relations Department
10 Chestnut St.
Worcester, MA 01608

What happens next?

If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of Fallon Community Health Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact information:

If you need information or help, call us at
1-800-868-5200 (TDD/TTY: 1-877-608-7677).

Other resources to help you:

Medicare Rights Center: 1-888-HMO-9050
Elder Care Locator: 1-800-677-1116
Medicare: 1-800-MEDICARE (1-800-633-4227),
TTY: 1-877-486-2048

continued

Grievances

A **grievance** is the type of complaint you make if you have any other type of problem with Fallon Community Health Plan, Fallon Senior Plan or one of our plan providers. You would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

How do I file a grievance?

Call the Member Relations Department at:
1-800-868-5200 (TDD/TTY: 1-877-608-7677)
Monday through Friday, 8 a.m. to 6 p.m.

Or send a letter including all details of your grievance to:

Fallon Community Health Plan
Member Relations Department
10 Chestnut St.
Worcester, MA 01608

A Member Relations representative will acknowledge your letter within 24 to 48 hours of receipt. Every reasonable attempt will be made to resolve your complaint within 25 days.

Exceptions to the formulary

You can ask Fallon Senior Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Fallon Senior Plan may limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can 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, you can ask us to cover it at the cost-sharing amount that applies to drugs in the lowest tier subject to the tiering exceptions process instead. This would lower the 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.

Generally, Fallon Senior Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects. Please note that because we do not cover drugs to treat erectile dysfunction, you will not be able to request a formulary exception for erectile dysfunction drugs when used to treat erectile dysfunction.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. When you are requesting a formulary, tiering, or utilization restriction exception, you should submit a statement from your physician supporting your request. Generally we must make our decision within 72 hours of getting your prescribing physician'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 your prescribing physician's supporting statement.

For more information about your appeals, grievances and exceptions, see your *Member Handbook/Evidence of Coverage*, or call us at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), seven days a week from 8 a.m. to 8 p.m.

