

Appeals and grievances: what to do if you have complaints

What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Customer Service at the number listed in the Eligible Person's Welcome Kit.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when someone makes a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from this Plan or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations, and appeals.

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, 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.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a coverage determination. When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations include exception requests. You have the right to ask us for an "exception" if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request an exception, your doctor must provide a statement to support your request.

You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

How to file a grievance

This part explains how to file a grievance.

A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below).

What types of problems might lead to you filing a grievance?

- You feel that you are being encouraged to leave (disenroll from) our Plan.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the plan sponsor to provide required notices.
- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

If you have a grievance, we encourage you to first call Customer Services at the number listed in the Eligible Person’s Welcome Kit. 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 in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints.** (Please refer the Eligible Person to the grievance procedure set forth in their Welcome Kit, which will include instructions about what they need to do if they want to use it). We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare prescription drug plan under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to, or in lieu of, a complaint filed under the Part D plan's grievance process. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. The introduction for more information about how to file a quality of care complaint with the QIO.

How to request a coverage determination

This part explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word “provide” in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that we will not cover a prescription drug, you should contact us and ask for a coverage determination. The following are examples of when you may want to ask us for a coverage determination:

- If you are not getting a prescription drug that you believe may be covered by us.
- If you have received a Part D prescription drug you believe may be covered by us while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a “formulary”). You can request an exception to our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the co-payment we require you to pay for a drug.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- If there is a requirement that you try another drug before we will pay for the drug you are requesting.

- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

The process for requesting a coverage determination is discussed in greater detail below in the section titled “Detailed information about how to request a coverage determination and an appeal.”

How to request an appeal

This part explains what you can do if you disagree with our coverage determination. If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

What kinds of decisions can be appealed?

- You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit.
- You can also appeal our decision not to reimburse you for a Part D drug that you paid for.
- You can also appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription.
- If we deny your exception request, explained in the Eligible Person’s Welcome Kit, you can appeal.
- A coverage determination, explained in the Eligible Person’s Welcome Kit, may be appealed if you disagree with our decision.

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

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one level to the next.** At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.
- **Who makes the decision at each level.** You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or part), you can go on to the first level of appeal by asking us to review our coverage

determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of this Plan, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the Federal court system. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail below in the section titled “Detailed information about how to request a coverage determination and an appeal.”

Detailed information about how to request a coverage determination and an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to request a coverage determination, or appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

Coverage Determinations: Our Plan makes a coverage determination about your Part D prescription drug, or about paying for a Part D drug you have already received.

What is a coverage determination?

The coverage determination made by the Eligible Person's Plan Sponsor 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 the Eligible Person's Plan Sponsor 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 drug you have already received. If we deny your request (this is sometimes called an “adverse coverage determination”), you can “appeal” our 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 determinations:

- You ask us to pay for a drug you have already received. This is a request for a coverage determination about payment. You can call Customer Service at the number listed in the Eligible Person's Welcome Kit to get help in making this request.
- You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can call Customer Service at the number listed in the Eligible Person's Welcome Kit to ask for this type of decision.

- You ask for an exception to our plan's utilization management tools. Requesting an exception to a utilization management tool is a type of formulary exception. You can call Customer Service at the number listed in the Eligible Person's Welcome Kit to ask for this type of decision.
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can call Customer Service at the number listed in the Eligible Person's Welcome Kit to ask for this type of decision.
- You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a doctor's office, will be covered by the plan. See the appropriate section in the Eligible Person's Welcome Kit for a description of these circumstances. You can call Customer Service at the number listed in the Eligible Person's Welcome Kit to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a doctor's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of the Eligible Person's Plan apply to your specific situation. The Eligible Person's Welcome Kit and any amendments you may receive describe the Part D prescription drug benefits covered by the Eligible Person's Plan, including any limitations that may apply to these benefits. The Eligible Person's Welcome Kit also lists exclusions (benefits that are "not covered" by the Eligible Person's Plan).

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some 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 act as your appointed representative. This statement must be sent to us at the Medicare Part D Sponsor's designated address listed in the Eligible Person's Welcome Kit. You can call Customer Service at the number listed in the Eligible Person's Welcome Kit, to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can 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 timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (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 sometimes called an "expedited coverage determination."

You can 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 requesting payment 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 refer to our Customer Service number listed in the Eligible Person's Welcome Kit for assistance. Or, you can deliver a written request to the Medicare Part D Sponsor's name and address listed in the Eligible Person's Welcome Kit or fax it to the Medicare Part D Sponsor at the fax number listed in the Eligible Person's Welcome Kit.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling us at the Medicare Part D Sponsor phone number listed in the Eligible Person's Welcome Kit. Or, you can deliver a written request to the Medicare Part D Sponsor name and address listed in the Eligible Person's Welcome Kit, or fax it to the Medicare Part D Sponsor at the fax number listed in the Eligible Person's Welcome Kit. 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 timeframe.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

1. For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.

Generally, we must give you our decision no later than 72 hours after we have received 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 make our decision no later than 72 hours after we have received your doctor's "supporting statement," which explains why the drug you are asking for is medically necessary. **If you are requesting an exception, you should submit your prescribing doctor's supporting statement with the request, if possible.** We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section titled "Appeal Level 1" explains how to file this appeal. If we have not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

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

If you get 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 must make our decision no later than 24 hours after we get your doctor's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary. We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision, under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision.

The section "Appeal Level 1" explains how to file this appeal. If we decide you are eligible for a fast review, and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case. If we do not grant you or your doctor's request for a fast review, we will give you our decision within the standard 72-hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. 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, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.

We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we get your

doctor's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we get the request.

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

We must authorize or provide you with the benefit you have requested no later than 24 hours after receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we get your doctor's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1).

Appeal Level 1:

If we deny all or part of your request in our coverage determination, you may ask us to reconsider our decision.

This is called an "appeal" or "request for redetermination."

Please call us at the Medicare Part D Sponsor phone number listed in the Eligible Person's Welcome Kit, if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we get your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and "Asking for a fast decision." [If you have your appeals sent to a different office than where your coverage determinations are sent, you should mention that while the process for deciding on a standard or fast appeal is the same as

in the case of a coverage determination, the place where the appeal is sent is different – refer them to “What if you want a ‘fast’ appeal” later in this section for more information.]

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to get and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor’s records or opinion to help support your request. You may need to give the doctor a written request to get information. You can give us your additional information in any of the following ways:

- In writing to the Medicare Part D Sponsor, name and address provided in Eligible Person’s Welcome Kit.
- By fax, at the Medicare Part D Sponsor fax phone number provided in the Eligible Person’s Welcome Kit
- By telephone -- if it is a fast appeal -- at the Medicare Part D Sponsor phone number provided in the Eligible Person’s Welcome Kit
- In person, at the Medicare Part D Sponsor name and address provided in Eligible Person’s Welcome Kit.

You can call or write us at the Medicare Part D Sponsor phone number provided in the Eligible Person’s Welcome Kit or the Medicare Part D Sponsor name and address provided in Eligible Person’s Welcome Kit.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing doctor.

How soon must you file your 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. To file a “standard” appeal, you can send the appeal to us in writing at the Medicare Part D Sponsor name and address provided in Eligible Person’s Welcome Kit.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling the Medicare Part D Sponsor phone number provided in the Eligible Person’s Welcome Kit. Or, you can deliver a written request to the Medicare Part D Sponsor name and address provided in Eligible Person’s Welcome Kit., or fax it to the

Medicare Part D Sponsor fax phone number provided in the Eligible Person's Welcome Kit. Be sure to ask for a "fast," "expedited," or "72-hour" review. [Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.] *[If you have appeals sent to a different office than where your coverage determinations are sent, you should mention that while the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different; also include instructions for where to send appeal requests.]*

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.*

After we get your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

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

After we get your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

We must send payment to you no later than 30 calendar days after we get your request to reconsider our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal -- or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization, to review your case. This independent review organization contracts with the Federal government and is not part of the Medicare Part D Sponsor.

Appeal Level 2:

If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the Independent Review Organization whose name and address is included in the redetermination notice you get from us.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing doctor cannot file the request for you-- only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." [Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, you will be automatically treated as eligible for a fast appeal.]

How soon must the independent review organization decide?

After the independent review organization gets your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it gets your request to give you a decision.

2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it gets the request to give you a decision.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. For a decision about reimbursement for a Part D drug you already paid for and received.

We must pay within 30 calendar days from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

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

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

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

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is met or exceeded according to the Eligible Person's Welcome Kit.

Appeal Level 3:

If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge (ALJ). You must make a request for review by an Administrative Law Judge in writing within 60

calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to include instructions about where and how to file appeal requests with the ALJ Field Office.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than the threshold (minimum amount specified) in the Eligible Person's Welcome Kit. If the dollar value is less than the stated threshold, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your co-payments, all costs incurred after your costs exceed the initial coverage limit, and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

- The claims involve the delivery of Part D prescription drugs to you;
- All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
- Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
- Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*
We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4:

Your case may be reviewed by the Medicare Appeals Council

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it.

What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

We must send payment to you no later than 30 calendar days from the date we get notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Council decides against you:

If the amount involved is an amount listed in the Eligible Person's Welcome Kit, or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than the amount listed in the Eligible Person's Welcome Kit, the Council's decision is final and you may not take the appeal any further.

**Appeal Level 5:
Your case may go to a Federal Court**

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case. If the contested amount is the amount listed in the Eligible Person's Welcome Kit, or more, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we get notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

We must send payment to you within 30 calendar days from the date we get notice reversing our coverage determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the appeal any further.