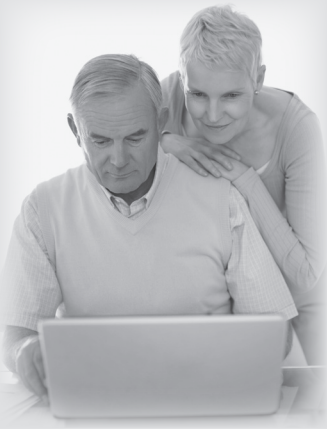
North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
*A Division of the Department of State Treasurer*

# Express Scripts Medicare™ Prescription Drug Plan Benefits Booklet 2013




Dear Member,

Welcome to the **State Health Plan for Teachers and State Employees**. To assist our Medicare-eligible retirees in understanding your pharmacy benefits, we have created this Express Scripts Medicare™ Prescription Drug Plan Benefits Booklet. This is your personal member guide with everything you need to know at your fingertips.

This Benefits Booklet will guide you through your plan information with ease. To help you locate what you need quickly, we've divided the book into the following sections:

- Quick Reference – easy access to the information that is most frequently needed.
- Express Scripts Medicare™ Prescription Drug Plan – detailed information about this prescription drug plan for Medicare-eligible members, along with contact information.

Traditional Pharmacy benefit information is located in the PPO Benefits Booklet.

For your convenience, we have additional ways for you to access your member information. Our website, **www.shpnc.org**, offers a variety of health-related resources including online forms, search tools to help you find a doctor, and general information about your plan. Additionally, our prompt and knowledgeable Customer Service department is just a phone call away at **877-680-4882**.

We are happy to have you as a member of the State Health Plan.

## Quick Reference - Toll Free Phone Numbers, Websites and Addresses

### SERVICES AND INFORMATION

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| **State Health Plan Website**<br>www.shpnc.org | To obtain information on contracting pharmacies, mental health and chemical dependency medical policies, search for a provider, obtain claim forms, obtain "proof of coverage" portability certificates, request ID cards, and more. |
| **Member Services**<br>www.shpnc.org | To enroll in a safe, secure customer service website to: Check claim status, verify benefits and eligibility, change your address or request a new ID card. |
| **Express Scripts Medicare Customer Service**<br>877-680-4882<br>24 hours a day, 7 days a week | For information regarding your Express Scripts Medicare pharmacy benefits, to obtain a formulary drug list, information on prior authorizations, refills, and more. |
| **Accredo Specialty Pharmacy**<br>877-988-0059 | For information regarding the specialty pharmacy services offered or to obtain specialty medications. |

### PRIOR AUTHORIZATION

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|---|---|
| **Express Scripts Medicare**<br>800-935-6103 | To initiate a prior authorization request for a prescription drug covered under the Express Scripts Medicare. |

### CLAIMS FILING

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| **Express Scripts Medicare Prescription Drug Claims Filing** | Mail completed prescription drug claim forms to:<br>Express Scripts, Inc.<br>ATTN: Direct Claims<br>P.O. Box 2824<br>Clinton, IA 52733-2824 |

### APPEALS

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| **Express Scripts Medicare Pharmacy Appeals**<br>800-935-6103 | See "What If You Disagree With A Decision?" section for more information. |

### ADDITIONAL RESOURCES

| | |
|---|---|
| **N.C. Department of State Treasurer**<br>**Retirement Systems Division**<br>325 North Salisbury Street<br>Raleigh, NC 27603-1385<br>919-733-4191 or 877-733-4191 toll-free<br>www.myncretirement.com | If you are a benefit recipient (Retirees, Beneficiaries, Disability recipients) and you have questions about your retirement benefits. |
| **Seniors' Health Insurance Information Program (SHIIP)**<br>11 South Boylan Avenue<br>Raleigh, NC 27603<br>800-443-9354 or 919-807-6900<br>www.ncdoi.com | If you are on Medicare and you have questions about your Medicare benefits. |

# Tips for Getting the Most Out of Pharmacy Benefits

### *Understand your pharmacy benefits*

The more you know about your benefits, the easier it will be to take control of your health. Let the State Health Plan help you understand your plan and use it effectively through our customer friendly website at **www.shpnc.org**, toll free Customer Service line (877-680-4882), and your benefits booklet.

### *Save on prescription drugs*

Print out the Formulary Drug List available at www.shpnc.org and take it with you when visiting your doctor. Ask your doctor to authorize a *generic* substitute whenever a *generic* is available. You will save money using *generics* since they have the lowest *copayment*. When there is more than one *brand name* drug available for your medical condition, it is suggested that you ask your physician to prescribe a drug on the preferred list.

## MEMBER RIGHTS AND RESPONSIBILITIES FOR YOUR PHARMACY BENEFITS

***As a State Health Plan member, you have the right to:***

- Receive, upon request, information about your pharmacy prescription benefit plan, a benefits booklet, evidence of coverage and directory of participating pharmacies
- Receive courteous service from the State Health Plan and its representatives
- Receive the reasons for the denial of a requested prescription drug
- Receive, upon request, information on the drug and clinical criteria used to determine whether a drug is investigational, experimental or requires prior approval
- Receive accurate, reader friendly information to help you make informed decisions about your pharmacy benefit
- Participate actively in all decisions related to your pharmacy benefit
- Expect that measures will be taken to ensure the confidentiality of your pharmacy benefit
- File an appeal and expect a fair and efficient appeals process for resolving any differences you may have with the coverage determination of your prescription drug
- Be treated with respect and recognition of your dignity and right to privacy
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the organization's members' rights and responsibilities policies

***As a State Health Plan member, you have the responsibility to:***

- Present your pharmacy ID card each time you receive services
- Read your benefits booklet and all other member materials
- Call State Health Plan Customer Service if you have a question or do not understand the material provided
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, tell your doctor
- Ensure any advance prior authorizations have been received for prescription drugs that require prior authorization
- File claims for out-of-network pharmacies in a complete and timely manner
- Participate in understanding your health problems and the medical decisions regarding your health care
- Notify the State Health Plan if you have any other group coverage
- Notify the State Health Plan of any changes regarding dependents and marital status as soon as possible
- Protect your pharmacy ID card from unauthorized use
- Notify the North Carolina State Retirement Systems of any address or phone number changes

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# EXPRESS SCRIPTS MEDICARE™ PRESCRIPTION DRUG PLAN (PDP) BENEFITS

You are eligible for this plan if you are entitled to Medicare Part A and/or are enrolled in Medicare Part B, live in the plan's service area, and are eligible for benefits from the State Health Plan. As a Medicare-eligible retiree, or the Medicare-eligible spouse of a retiree, who is currently receiving benefits, you will automatically be enrolled in the plan.

You can only be enrolled in one Medicare prescription drug plan at a time. If you are currently enrolled in a Medicare Advantage (MA) Plan that **includes Medicare prescription drug coverage,** your enrollment in this plan will end that enrollment. In addition, you may not be enrolled in an individual MA Plan—even one without prescription drug coverage—at the same time as this plan. Please contact State Health Plan Customer Service at 888-234-2416 if you have questions about other plan types and the impact your enrollment in this plan may have.

**Initial Coverage stage**

You stay in this stage until you reach the member out-of-pocket maximum of $2,500, or until your total yearly drug costs (what you and the plan pay) reach $2,970, whichever comes first. During this stage, you will pay the following:

| Tier | Retail One-Month (31-day) Supply | Retail Three-Month (90-day) Supply | Mail Three-Month (90-day) Supply |
|---|---|---|---|
| Tier 1: **Generic Drugs** | $12 copayment | $36 copayment | $36 copayment |
| Tier 2: **Preferred Brand Drugs** | $40 copayment | $120 copayment | $120 copayment |
| Tier 3: **Non-Preferred Brand Drugs** | $64 copayment | $192 copayment | $192 copayment |
| Tier 4: **Specialty Tier Drugs** | 25% coinsurance $100 maximum | 25% coinsurance $300 maximum | 25% coinsurance $300 maximum |

Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. You may also receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) through our Pharmacy Benefit Manager (PBM), Express Scripts. Please refer to your *Pharmacy Directory* or contact Express Scripts Medicare Customer Service at the number listed in the "Quick Reference Guide" for more information.

As part of the Medication Adherence Program (MAP), members may obtain a 90-day supply of chronic cardiovascular and diabetes medications at participating network pharmacies for 2 ½ copays. Please refer to the State Health Plan website or the Express Scripts website for a list of eligible medications and participating pharmacies.

| | |
|---|---|
| **Coverage Gap stage** | This plan **does not** have a "donut hole." Due to additional coverage being provided by the State Health Plan, you will continue to pay the same copays throughout all stages until you reach the Catastrophic Coverage stage. If you have not met the member out-of-pocket maximum of $2,500 but your total yearly drug costs reach $2,970, you will pay the same cost-sharing amount as in the Initial Coverage stage until your yearly out-of-pocket drug costs reach $4,750. |
| **Catastrophic Coverage stage** | If you have not met your member out-of-pocket maximum, but your yearly out-of-pocket drug costs—including manufacturer discounts—exceed $4,750, you will pay the greater of 5% coinsurance or:<br>• a $2.65 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard cost-share during the Initial Coverage stage.<br>• a $6.60 copayment for all other covered drugs, with a maximum not to exceed the standard cost-share during the Initial Coverage stage. |
| **Member Out-of-Pocket Maximum** | This plan has a yearly member out-of-pocket maximum (costs paid by yourself only) of $2,500. Once you reach this amount, you will pay $0 for your covered prescription drugs for the remainder of the plan year. |

Your Medicare *prescription* benefit covers federal legend *prescription drugs*, injectable medications, insulin and certain over-the-counter medications. See "Formulary Exclusions" for those drugs that are not covered by your pharmacy benefit plan.

Some *prescription drugs* may require *certification*, also known as prior approval or prior authorization, or be subject to step therapy or formulary coverage review in order to be covered. It is very important to make sure that prior approval is received before going to the pharmacy.

Some *prescription drugs* may be subject to quantity limits based on criteria developed by the *State Health Plan* or its representative. Prior approval is required before excess quantities of these drugs will be covered. If you need quantities in excess of the limit for a drug that is subject to quantity limits, it is important to make sure your *provider* has received prior approval before going to the pharmacy. For a list of *prescription drugs* that require prior approval to be covered or require approval for additional quantities, refer to the formulary located in your Welcome Kit or visit www.shpnc.org. Express Scripts may periodically add or remove drugs to the formulary, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. If any formulary change limits your ability to fill a prescription, you will be notified before the change is made.

**For authorization of your *prescription drugs*, your physician may call the *Express Scripts'* Prior Authorization number listed in** the "Quick Reference Guide" **to initiate an *authorization* request.**

## *Using Express Scripts Medicare Participating Network Pharmacies*

Most chain and independent pharmacies contract with Express Scripts. You may obtain information about which pharmacies are contracting by visiting the *State Health Plan's* website or calling Express Scripts Medicare Customer Service at the number listed in the "Quick Reference Guide".

You must use Express Scripts Medicare participating network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You may incur additional

costs for drugs received at an out-of-network pharmacy. Call Express Scripts Medicare Customer Service at the number listed in the "Quick Reference Guide" for more information.

The service area for this plan is all 50 states, the District of Columbia, and Puerto Rico. You must live in one of these areas to be eligible for this plan.

The convenience of mail order pharmacy is available for your maintenance medications by using the plan's online pharmacy services, by telephone, or by completing a Mail Service Order Form and returning it with your original *prescription* and appropriate *copayment* directly to the plan's mail order pharmacy. You may obtain a Mail Service Order Form on the *State Health Plan's* website or by calling the plan at 888-234-2416. To learn how to register for the plan's online pharmacy services, visit the *State Health Plan's* website at www.shpnc.org.

You may use a credit card for *copayments* for telephone or online refills.

### *Formulary (Drug List)*

The formulary contains a list of highly utilized Medicare Part D drugs selected by the plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The plan may provide coverage of additional Medicare Part D drugs that are not listed in this formulary and some medications may have lower copays. Refer to the State Health Plan website for a list of medications with reduced copays.

The formulary can be obtained from the *State Health Plan's* website or by calling Express Scripts Medicare Customer Service at the number listed in the "Quick Reference Guide." The formulary is subject to change, in which case you will be notified within 60 days of the change.

- *Generic* drugs are often an effective alternative to brand drugs. Ask your physician to consider *generic* drugs whenever possible. If a *generic* drug is not available, you will be responsible for paying the higher *copayment* based on the tier placement for the *brand name* drug.
- When there is more than one *brand name* drug available for your medical condition, it is suggested that you ask your physician to prescribe a drug on the preferred list. This will reduce your *copayment*.

A *prescription* cannot be refilled until three fourths (3/4) of the medication has been used as prescribed by your physician; exceptions may apply to certain prior authorized drugs.

### Formulary Exclusions

- Any *prescription drugs* not FDA approved
- Any *prescription drugs* that are not federal legend
- Any *prescription drugs* not specifically covered by the *State Health Plan*
- Any *prescription drugs* prescribed for *sexual dysfunction*
- Any *prescription* drugs prescribed for *infertility*
- Any *prescription drugs* prescribed for hair growth
- Any *prescription drugs* prescribed for cosmetic purposes
- Any *prescription drugs* prescribed in conjunction with artificial reproductive technology
- Any *prescription drug* in excess of the stated quantity limits
- Any *prescription drug* requiring *authorization* if *authorization* is not obtained
- Any drug that can be purchased over the counter without a *prescription*, even though a written *prescription* is provided, except for insulin and other *State Health Plan* approved over-the-counter drugs
- Any compound drug that contains an investigational drug or does not contain a covered prescription drug

### *Diabetic Testing Supplies*

Diabetic testing supplies are covered under your pharmacy benefit. For a single *copayment*, insulin *dependent members* may receive up to 153 test strips (depending on manufacturer's packaging) and non-insulin *dependent members* may receive 50 or 51 (depending on manufacturer's packaging) test strips per 31-day

supply. Additional test strips are covered under your medical supply benefit and are subject to *deductible* and *coinsurance.*

### Specialty Pharmacy

Specialty medication can be a brand or generic drug that typically costs $600 or more per month and has: complex therapy for complex disease; specialized patient training and coordination of care required prior to and/or during therapy; unique safety monitoring requirement; unique requirements for handling, shipping, and storage. If you use a specialty medication, you may obtain the medication from any in-network Express Scripts Medicare participating **retail** pharmacy as well as Accredo.

A list of the available specialty medications is available on the *State Health Plan's* website.

Accredo, the State Health Plan's Specialty Pharmacy, deals exclusively with supplying medications to treat complex conditions and provides a high level of care for patients with chronic or serious conditions, who take medications that require injection, special handling and monitoring. For more information regarding the services Accredo provides contact the number listed in the "Quick Reference Guide."

### How To File A Claim For Prescription Drugs

When you use an in-network Express Scripts Medicare participating pharmacy, present your Pharmacy *ID card* to the pharmacist and you will not be required to pay more than the appropriate *copayment* for each 31-day supply. The pharmacist will file the claim.

If you purchased *prescription drugs* from a pharmacy not contracted with Express Scripts during special circumstances, you will be responsible for the total amount of the *prescription* at the time of purchase. You will be reimbursed for your costs minus the applicable *copayment* and charges in excess of the *allowed amount*. You will need to complete a *Prescription Drug* Claim Form for reimbursement and submit it to:

Express Scripts
PO Box 14718
Lexington, KY 40512

If you are sending the original pharmacy receipts, the following information is required in order to process the claim:

- Pharmacy name
- *Prescription* number
- Drug name and National Drug Code (NDC)
- Date purchased
- Strength
- Quantity
- Drug charge
- Pharmacist's signature
- Days supply

Complete a separate form for each family member and pharmacy.

**Drug receipts from the label or bag should not be submitted. Claims will be returned if not properly completed.** For information on how to properly submit a pharmacy claim, call Express Scripts Customer Service at the number given in the "Quick Reference Guide."

### Long-Term Care (LTC) Pharmacy

Residents of a long-term care facility using an in-network LTC pharmacy will pay the cost-sharing amount for a one-month supply at retail for each stage noted in the preceding chart.

### Out-of-Network Coverage

You must use Express Scripts Medicare participating network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness

while traveling outside of the plan's service area where there is no network pharmacy. You may incur additional costs for drugs received at an out-of-network pharmacy.

The service area for this plan is all 50 states, the District of Columbia, and Puerto Rico. You must live in one of these areas to join this plan. Express Scripts may reduce our service area and no longer offer services in the area in which you reside.

### Qualifying for Extra Help

To see if you qualify for Extra Help, call Medicare at 800-MEDICARE (800-633-4227), 24 hours a day/7 days a week (TTY users should call 877-486-2048); the Social Security Office at 800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday (TTY users should call 800-325-0778); or your State Medicaid Office. The Seniors' Health Insurance Information Program (SHIIP) can also assist you with applying for Extra Help. SHIIP is available by calling 800-443-9354 or 919-807-6900 Monday-Friday from 8 a.m. to 5 p.m. If you qualify, Medicare will tell the plan how much assistance you will receive, and Express Scripts will send you information on the amount you will pay once you are enrolled in this plan.

### Income and my Medicare Part D Premium

Some people have to pay an extra amount because of their yearly income. If you have to pay an extra amount, Social Security—not your Medicare plan—will send a letter telling you what the extra amount will be and how to pay it. If your Social Security benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. If you have any questions about this, contact Social Security at 800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 800-325-0778.

### Medicare Part B or Part D Drugs

This prescription plan provides coverage for Medicare Part B medications, as well as several categories of other non-Part D medications that are not normally covered by a Medicare prescription drug plan. The amounts paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please see your formulary for additional information.

### Medication Therapy Management (MTM) Program

A Medication Therapy Management (MTM) Program is a free service Express Scripts offers to help you manage your medications. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact Express Scripts Medicare for more details.

## *WHAT IF YOU DISAGREE WITH A DECISION REGARDING EXPRESS SCRIPTS MEDICARE?*

Express Scripts Medicare uses the following five-level appeals process for members. A member has the right to appeal a decision if he/she thinks the State Health Plan:

- is discontinuing care which is necessary.
- does not authorize or give care understood to be covered.
- has not paid a bill it should pay or has not paid a bill in full that it should have.
- is delaying the provider arrangement or approval of health care service, and the delay is affecting the member's health.

### *Section 1: Introduction*

#### Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- One for **coverage decisions and making appeals**
- And another process **for making complaints**

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you. Which one do you use? That depends on the type of problem you are having. The guide in **Section 3** will help you identify the right process to use.

#### Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible. However, it can be helpful—and sometimes quite important—for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

### *Section 2: You can get help from government organizations that are not connected with us*

#### Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

**Get help from an independent government organization**

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected to us.

You can always contact the Seniors' Health Insurance Information Program (SHIIP). This government program has trained counselors in every state. The program is not connected with Express Scripts, the State Health Plan or with any insurance company or health plan.

The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIIP counselors are free. You will find phone numbers in the "Quick Reference Guide."

**You can also get help and information from Medicare**

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

## *Section 3: To deal with your problem, which process should you use?*

### Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, read the parts of this chapter that apply to your situation. The guide that follows on the next page will help.

| To figure out which part of this chapter will help with your specific problem or concern, **START HERE** | |
|---|---|
| **Is your problem or concern about your benefits or coverage?** (This includes problems about whether particular prescription drugs are covered or not, the way in which they are covered, and problems related to payment for prescription drugs.) | |
| **Yes.** My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4: A guide to the basics of coverage decisions and appeals.** | **No.** My problem is not about benefits or coverage. Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, Customer Service, or other concerns.** |

**Coverage decisions and appeals**

## *Section 4: A guide to the basics of coverage decisions and appeals*

### Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

## *WHAT IF YOU DISAGREE WITH A DECISION REGARDING EXPRESS SCRIPTS MEDICARE?*

**Asking for coverage decisions**

A coverage decision is a decision Express Scripts makes about your benefits and coverage or about the amount they will pay for your prescription drugs. A coverage decision is made whenever Express Scripts decides what is covered for you and how much we pay. In some cases, Express Scripts might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

**Making an appeal**

If a coverage decision is made and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking Express Scripts to review and change a coverage decision that has been made. When you make an appeal, Express Scripts will review the coverage decision made to check to see if all of the rules are being followed properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When the review has been completed, Express Scripts gives you our decision.

If Express Scripts says no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

### Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are listed on the back of your Member ID card).
- To **get free help from an independent organization** that is not connected with our plan, contact the Seniors' Health Insurance Information Program (SHIIP) (see **Section 2** of this chapter for more information).
- **For your Part D prescription drugs,** your doctor or other prescriber can request a coverage decision or a Level 1 or 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under state law.
    - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Service (phone numbers for Customer Service are listed on the back of your Member ID card) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to 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. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

## *Section 5: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal*

**?** Have you read **Section 4** of this chapter, *A guide to the basics of coverage decisions and appeals?* If not, you may want to read it before you start this section.

### Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to the 2013 *Formulary (List of Covered Drugs)*. 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 FDA or supported by certain reference books. Refer to the Evidence of Coverage **Chapter 3, Section 3, which is located in your Welcome Kit,** for more information about a medically accepted indication.)

- This section is about your Part D drugs only**.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the 2013 *Formulary (List of Covered Drugs)*, rules and restrictions on coverage, and cost information, see **Chapter 3 in the Evidence of Coverage, which is located in your Welcome Kit,** (*Using the plan's coverage for your Part D prescription drugs*) and **Chapter 4 in the Evidence of Coverage,** (*Paying for your Part D prescription drugs*).

#### Part D coverage decisions and appeals

As discussed in **Section 4**, a coverage decision is a decision made about your benefits and coverage or about the amount we will pay for your drugs.

| | |
|---|---|
| **Legal Terms** | An initial coverage decision about your Part D drugs is called a **coverage determination.** |

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

- You ask to make an exception, including:
    - Asking 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 non-preferred drug
- You ask whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is covered by the plan, but Express Scripts requires you to get approval before it will be covered.)
    - Please note: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice from the pharmacy explaining how to contact Express Scripts to ask for a coverage decision.
- You ask to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision that has been made, you can appeal the decision.

## *WHAT IF YOU DISAGREE WITH A DECISION REGARDING EXPRESS SCRIPTS MEDICARE?*

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

| **Which of these situations are you in?** | | | |
|---|---|---|---|
| **Do you want Express Scripts to waive a rule or restriction on a drug we cover?** | **Do you believe you have met any plan rules or restrictions (such as getting approval in advance) for the drug you need?** | **Do you want to ask Express Scripts to pay you back for a drug you have already received and paid for?** | **Has Express Scripts already told you that they will not cover or pay for a drug in the way that you want it to be covered or paid for?** |
| You can ask Express Scripts to make an exception. (This is a type of coverage decision.) | You can ask Express Scripts for a coverage decision. | You can ask Express Scripts to pay you back. (This is a type of coverage decision.) | You can make an appeal. (This means you are asking for a reconsideration.) |
| Start with **Section 5.2** | Skip ahead to **Section 5.4** | Skip ahead to **Section 5.4** | Skip ahead to **Section 5.5** |

### Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask for an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if Express Scripts turns 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. Express Scripts will then consider your request. Here are examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs covered (for more information, refer to the Evidence of Coverage in **Chapter 3**).

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| **Legal terms** | Asking for removal of a restriction on coverage for a drug is sometimes called asking for an **exception.** |

- The extra rules and restrictions on coverage for certain drugs include:
  - *Getting plan approval in advance* before Express Scripts will agree to cover the drug for you. (This is sometimes called **prior authorization.**)
  - *Being required to try a different drug first* before Express Scripts agrees 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 Express Scripts agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount you need to pay for the drug.

2. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in a specific cost-sharing tier. You can see what tier a drug is in by looking in your 2013 *Formulary (List of Covered Drugs)*. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

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| **Legal Terms** | Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **tiering exception.** |

- If your drug is in a Non-Preferred Brand Tier, you can ask for it to be covered at the cost-sharing amount that applies to drugs in the Preferred Brand Tier. This would lower your share of the cost for the drug.

### Section 5.3 Important things to know about asking for exceptions

**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give Express Scripts 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, the plan's coverage 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, Express Scripts will generally *not* approve your request for an exception.

**Express Scripts can say yes or no to your request**

- If your request for an exception is approved, the 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 Express Scripts says no to your request for an exception, you can ask for a review of the decision by making an appeal. **Section 5.5** tells you how to make an appeal if Express Scripts says no.

The next section tells you how to ask for a coverage decision, including an exception.

### Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

**Step 1 You ask for a coverage decision about the drug(s) or payment you need.**

If your health requires a quick response, you must ask us to make a **"fast decision." You cannot ask for a fast decision if you are asking the plan 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 Express Scripts to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, refer to the Evidence of Coverage **Chapter 2, Section 1, which is located in your Welcome Kit,** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request asking us to pay for our share of the cost of a drug you have received.*

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. **Section 4** tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask Express Scripts to pay you back for a drug,** start by reading the Evidence of Coverage **Chapter 5, which is located in your Welcome Kit**: *Asking us to pay our share of the costs for covered drugs.* The Evidence of Coverage **Chapter 5** describes the situations in which you may need to ask for reimbursement. It also tells how to send the paperwork that asks the plan to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the supporting statement.** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (This is called the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to Express Scripts. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See **Sections 5.2** and **5.3** for more information about exception requests.

*If your health requires it, ask for a fast decision*

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| **Legal terms** | A fast decision is called an **expedited coverage determination.** |

- When Express Scripts gives you a decision, the "standard" deadlines will be used unless they have agreed to use the "fast" deadlines. A standard decision means you will have an answer within 72 hours after your doctor's statement has been received. A fast decision means Express Scripts will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision *only* if you are asking for a *drug you have not yet received.* (You cannot get a fast decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast decision *only* if using *the standard deadlines could cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells Express Scripts that your health requires a fast decision, they will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), Express Scripts will decide whether your health requires that we give you a fast decision.
  - If they decide that your medical condition does not meet the requirements for a fast decision, they will send you a letter that says so (and use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, Express Scripts will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see **Section 7** of this chapter.)

**Step 2 Express Scripts will consider your request and give you an answer.**

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| Deadlines for a **fast** coverage decision |

- If Express Scripts is using the fast deadlines, they must give you an answer **within 24 hours.**

- Generally, this means within 24 hours after receipt of your request. If you are requesting an exception, Express Scripts will give you an answer within 24 hours after they receive your doctor's statement supporting your request. Express Scripts will give you an answer sooner if your health requires it.
- If this deadline is not met, Express Scripts is required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, there is information about this review organization and an explanation of what happens at Appeal Level 2.

- **If the answer is yes to part or all of what you requested,** Express Scripts must provide the coverage they have agreed to provide within 24 hours after they receive your request or doctor's statement supporting your request.
- **If the answer is no to part or all of what you requested,** Express Scripts will send you a written statement that explains why they said no.

Deadlines for a **standard** coverage decision about a drug you have not yet received

- If the standard deadlines are being used, Express Scripts must give you an answer **within 72 hours.**
  - Generally, this means within 72 hours after they receive your request. If you are requesting an exception, they will give you an answer within 72 hours after they receive your doctor's statement supporting your request. They will give you an answer sooner if your health requires it.
  - If they do not meet this deadline, they are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, they tell about this review organization and explain what happens at Appeal Level 2.
- **If the answer is yes to part or all of what you requested:**
  - If Express Scripts approves your request for coverage, they must **provide the coverage** they have agreed to provide **within 72 hours** after they receive your request or doctor's statement supporting your request.
- **If the answer is no to part or all of what you requested,** Express Scripts will send you a **written statement** that explains why they said no.

Deadlines for a **standard** coverage decision about payment for a drug you have already bought

- Express Scripts must give you an answer **within 14 calendar days** after they receive your request.
  - If they do not meet this deadline, they are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, they tell about this review organization and explain what happens at Appeal Level 2.
- **If the answer is yes to part or all of what you requested,** Express Scripts is also required to make payment to you within 14 calendar days after they receive your request.
- **If the answer is no to part or all of what you requested,** Express Scripts will send you a written statement that explains why they said no.

**Step 3 If Express Script says no to your coverage request, you decide if you want to make an appeal.**

- If Express Scripts say no, you have the right to request an appeal. Requesting an appeal means asking them to reconsider—and possibly change—the decision that was made.

### Section 5.5 Step-by-step: How to make a Level 1 Appeal

(how to ask for a review of a coverage decision made by the plan)

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| **Legal terms** | An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** |

**Step 1 Contact Express Scripts and make your Level 1 Appeal.** If your health requires a quick response, you must ask for a **fast appeal.**

*What to do*

- **To start your appeal, you, your doctor, or your representative must contact Express Scripts.**
  - For details on how to reach Express Scripts by phone, fax, or mail, for any purpose related to your appeal, refer to the Evidence of Coverage **Chapter 2, Section 1,** and look for the section called *How to contact us when you are asking for a coverage decision or an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling Express Scripts at the phone number shown in the Evidence of Coverage **Chapter 2, Section 1, which is located in your Welcome Kit,** (*How to contact Express Scripts when you are asking for a coverage decision or an appeal about your Part D prescription drugs.*)
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call the phone numbers shown in** the Evidence of Coverage **Chapter 2, Section 1, which is located in your Welcome Kit,** *(How to contact Express Scripts when you are asking for a coverage decision or an appeal about your Part D prescription drugs.)*
- **You must make your appeal request within 60 calendar days** from the date on the written notice they sent to tell you an answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, they may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting Express Scripts or if they provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask Express Scripts for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give Express Scripts additional information to support your appeal.

*If your health requires it, ask for a fast appeal*

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|---|---|
| **Legal terms** | A fast appeal is also called an **expedited reconsideration.** |

- If you are appealing a decision they made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast decision in **Section 5.4** of this chapter.

**Step 2 Express Scripts will consider your appeal and give you an answer.**

- When Express Scripts is reviewing your appeal, they take another careful look at all of the information about your coverage request. They check to see if they were following all the rules when they said no to your request. They may contact you or your doctor or other prescriber to get more information.

Deadlines for a **fast appeal**

- If they are using the fast deadlines, they must give you an answer **within 72 hours after they receive your appeal.** They will give you an answer sooner if your health requires it.
    - If they do not give you an answer within 72 hours, they are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, they tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If the answer is yes to part or all of what you requested,** they must provide the coverage they have agreed to provide within 72 hours after they receive your appeal.
- **If the answer is no to part or all of what you requested,** they will send you a written statement that explains why they said no and how to appeal our decision.

Deadlines for a **standard appeal**

- If they are using the standard deadlines, they must give you an answer **within 7 calendar days** after they receive your appeal. They will give you a decision sooner if you have not received the drug yet and your health condition requires them to do so. If you believe your health requires it, you should ask for a "fast" appeal.
    - If they do not give you a decision within 7 calendar days, they are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, they tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**
    - If they approve a request for coverage, they must **provide the coverage** they have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after they receive your appeal.
    - If they approve a request to pay **you back for a drug** you already bought, they are required to **send payment to you within 30 calendar days after they receive** your appeal request.
- **If our answer is no to part or all of what you requested,** they will send you a written statement that explains why they said no and how to appeal our decision.

**Step 3 If Express Scripts says no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.**

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

### Section 5.6 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when Express Scripts said no to your first appeal. This organization decides whether the decision they made should be changed.

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| **Legal terms** | The formal name for the Independent Review Organization is the **Independent Review Entity.** It is sometimes called the **IRE.** |

**Step 1 To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.**

- If our plan says no to your Level 1 Appeal, the written notice they send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, they will send the information they have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

**Step 2 The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for **fast appeal** at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal.
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** they must provide the drug coverage that was approved by the review organization **within 24 hours** after they receive the decision from the review organization.

Deadlines for **standard appeal** at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested:**
    - If the Independent Review Organization approves a request for coverage, they must **provide the drug coverage** that was approved by the review organization **within 72 hours** after they receive the decision from the review organization.
    - If the Independent Review Organization approves a request to pay you back for a drug you already bought, they are required to **send payment to you within 30 calendar days** after they receive the decision from the review organization.

**What if the 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 and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. 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.

**Step 3 If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge. **Section 6** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## *Section 6: Taking your appeal to Level 3 and beyond*

### Section 6.1 Levels of Appeal 3, 4, and 5 for Part D drug appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 Appeal:** **A judge who works for the federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process is over.** What you asked for in the appeal has been approved. They must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after they receive the decision.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal:** The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. Express Scripts must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after they receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal:** A judge at the **Federal District Court** will review your appeal and make a decision.

- This is the last step of the appeals process.

## MAKING COMPLAINTS

## *Section 7: How to make a complaint about quality of care, waiting times, Customer Service, or other concerns*

? If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

### Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the Customer Service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of the following kinds of problems or concerns, you can make a complaint:

- If you are unhappy with the quality of care received

- If you feel someone did not respect your right to privacy or has shared information you feel should be confidential
- If you feel someone treated you disrespectfully
- If you received poor Customer Service
- If you feel you are being encouraged to leave the plan
- If you were kept waiting too long at the pharmacy or by Customer Service
- If you are unhappy with the condition or cleanliness of the pharmacy
- If you feel they have not given you a notice they are required to give or that written information was too difficult to understand

**These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals:**

The process of asking for a coverage decision and making appeals is explained in **Sections 4-6** of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that they are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and they have said they will not, you can make a complaint.
- If you believe they are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision they made is reviewed and they are told that they must cover or reimburse you for certain drugs, there are deadlines that apply. If you think they are not meeting these deadlines, you can make a complaint.

When they do not give you a decision on time, they are required to forward your case to the Independent Review Organization. If they do not do that within the required deadline, you can make a complaint.

### Section 7.2 The formal name for making a complaint is filing a grievance

**Legal terms**

- What this section calls a **complaint** is also called a **grievance.**
- Another term for **making a complaint** is **filing a grievance.**
- Another way to say **using the process for complaints** is **using the process for filing a grievance.**

### Section 7.3 Step-by-step: Making a complaint

**Step 1 Contact us promptly – either by phone or in writing.**

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Call us at the phone numbers listed on the back of your Member ID card.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, they will respond to your complaint in writing.
    - If you have a complaint or grievance, you or your representative may call Customer Service at the phone numbers listed on the back of your Member ID card. An attempt will be made to resolve your complaint over the phone. If you ask for a written response or your complaint is related to quality of care, they will respond in writing to you. If they cannot resolve your complaint over the

phone, they have a formal procedure to review your complaint. This process is called "Express Scripts Medicare Complaints and Grievances." Regarding expedited processing for initial determinations and redeterminations, Express Scripts approves requests either orally or in writing within the timeframes outlined in **Section 5.4** of this chapter for coverage determinations and in **Section 7.3** of this chapter for complaints.

- If you prefer to state your grievance in writing, please send a grievance form or a letter with as much detail as possible to: Express Scripts Medicare, Express Scripts, Attn.: Grievance Resolution Team, P.O. Box 630035, Irving, TX 75063-0035. All grievances received in writing will be responded to in writing.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because they denied your request for a fast response to a coverage decision or appeal, they will automatically give you a fast complaint.** If you have a "fast" complaint, it means they will give you **an answer within 24 hours.**

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|---|---|
| **Legal terms** | What this section calls a **fast complaint** is also called an **expedited grievance.** |

**Step 2 Express Scripts looks into your complaint and gives you an answer.**

- **If possible, they will answer you right away.** If you call us with a complaint, they may be able to give you an answer on the same phone call. If your health condition requires an answer quickly, they will do that.
- **Most complaints are answered in 30 calendar days.** If they need more information and the delay is in your best interest or if you ask for more time, they can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If they do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, they will let you know. The response will include the reasons for this answer. They must respond whether they agree with the complaint or not.

### Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about *quality of care,* you also have two additional options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, refer to the Evidence of Coverage located in your Welcome Kit. If you make a complaint to this organization, Express Scripts will work with them to resolve your complaint.

**Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

## *WHAT IF YOU DISAGREE WITH A DECISION REGARDING EXPRESS SCRIPTS MEDICARE?*

### Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about Express Scripts Medicare directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 800-MEDICARE (800-633-4227). TTY users can call 877-486-2048.

## *DEFINITIONS*

ALLOWED AMOUNT — the maximum amount in which payment is based upon for a covered prescription drug.

APPEAL — an appeal is something you do if you disagree with a decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if the plan doesn't pay for a drug you think you should be able to receive. Sections 4 and 5 explain appeals, including the process involved in making an appeal.

BRAND-NAME DRUG — a prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

CERTIFICATION — the determination by the *State Health Plan* or its representative that supplies or drugs have been reviewed and, based on the information provided, satisfy the requirements for *medically necessary* services and supplies, appropriateness, health care setting, level of care and effectiveness.

COINSURANCE — an amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles (if they apply). Coinsurance is usually a percentage (for example, 20%).

COPAYMENT — an amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

COVERED DRUG(S) — the term the plan uses to mean all of the prescription drugs covered by this plan.

DEDUCTIBLE — the amount you must pay for prescriptions before this plan begins to pay (if your plan has a deductible).

DOCTOR — includes the following: a *doctor* of medicine, a *doctor* of osteopathy, licensed to practice medicine or *surgery* by the Board of Medical Examiners in the state of practice, a *doctor* of dentistry, a *doctor* of podiatry, a *doctor* of chiropractic, a *doctor* of optometry, or a *doctor* of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right, subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

EMPLOYEE — the person who is eligible for coverage under the *State Health Plan* due to employment with the State of North Carolina, including, but not limited to teachers, state *employees*, *retirees*; certain members of boards and commissions; certain counties and municipalities; firemen and rescue workers; National Guard; and anyone else eligible pursuant to North Carolina General Statutes.

EVIDENCE OF COVERAGE (EOC) – this document, along with your eligibility record and any other attachments, riders, or other optional coverage selected, which explains your coverage, what you must do, your rights, and what you have to do as a member of the plan.

EXPRESS SCRIPTS MEDICARE™ PRESCRIPTION DRUG PLAN (PDP) — All Medicare-eligible members are automatically enrolled in this plan. This plan is comparable to the Traditional Pharmacy Plan and offers better coverage than a standard Medicare Part D Plan.

FORMULARY (List of Covered Drugs) or Drug List — a list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs. This list contains the most commonly used drugs and does not include all Part D drugs covered by this plan.

GENERIC DRUG — a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

GRIEVANCE — a type of complaint you make about the plan or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

IDENTIFICATION CARD (ID card) — the card issued to *subscribers* upon enrollment which provides your *member* identification numbers, names of the *members,* applicable *copayments* and/or *coinsurance,* and key phone numbers and addresses.

INFERTILITY — the inability of a heterosexual couple to conceive a child after 12 months of unprotected male/female intercourse.

INVESTIGATIONAL (EXPERIMENTAL) DRUG – a drug that has not been approved by the U.S. Food and Drug Administration (FDA) and is in the process of being tested for safety and efficacy.

MEDICALLY NECESSARY (or MEDICAL NECESSITY) — those *covered services* or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under this health benefit plan, not for *experimental*, *investigational*, or *cosmetic* purposes.
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of *medical care* in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the *provider*.

For *medically necessary* services, the *State Health Plan* or its representative may compare the cost effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting *medically necessary* services are eligible for coverage.

MEMBER — a person with Medicare who is eligible to get covered services, who has enrolled in this plan, and whose enrollment has been confirmed by the Centers for Medicare and Medicaid Services (CMS).

NETWORK PHARMACY — a pharmacy where members can get their prescription drug benefits. They are called “network pharmacies” because they contract with Express Scripts. In most cases your prescription is covered only if filled at a network pharmacy.

OUT-OF-NETWORK PHARMACY — a pharmacy that doesn’t have a contract with Express Scripts to coordinate or provide covered drugs to members of this plan. As explained in this Evidence of Coverage, which is located in the Welcome Kit, most drugs you get from out-of-network pharmacies are not covered by this plan unless certain conditions apply.

PHARMACY BENEFIT MANAGER (PBM) — the company with which the State of North Carolina contracts to manage the *prescription drug* benefit.

PRESCRIPTION — an order for a *drug* issued by a *provider* duly licensed to make such a request in the ordinary course of professional practice; or requiring such an order.

PRESCRIPTION DRUG — a drug that has been approved by the Food and Drug Administration (FDA) and is required, prior to being dispensed or delivered, to be labeled "Caution: Federal law prohibits dispensing without *prescription*,” or labeled in a similar manner (also known as a federal legend drug), and is appropriate to be administered without the presence of a medical supervisor.

PRIOR AUTHORIZATION — a type of plan restriction requiring approval in advance to get certain drugs that may or may not be on your formulary. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from the plan. Covered drugs that need prior authorization are marked in the formulary.

PROVIDER — a *hospital, nonhospital facility, doctor*, *other provider*, or *other professional providers* accredited, licensed or certified where required in the state of practice, performing within the scope of license or *certification*. All services performed must be within the scope of license or *certification* to be eligible for reimbursement.

RETIREE — an enrolled retired *employee* who receives monthly retirement benefits from any retirement system supported in whole or in part by contributions of the State of North Carolina and who is eligible for benefits pursuant to North Carolina General Statutes.

SEXUAL DYSFUNCTION — any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

SPECIALTY MEDICATION – high-cost drug used to treat a complex condition. These drugs usually require injection and special handling. Medicare allows plans to include these drugs in a separate “specialty” drug tier if they cost more than $600 per month.

SPOUSE — the husband or wife of an *employee* or *retiree* who enters into a marriage that is legally recognized by the State of North Carolina.

STATE HEALTH PLAN — the state organization authorized pursuant to North Carolina General Statutes to make available the State Health Plan for Teachers and State Employees and optional *hospital* and medical benefits and programs to *employees* and *dependents*.
SUBSCRIBER — the *employee* who is eligible for coverage under the *Plan* and who is enrolled for coverage.
TRADITIONAL PHARMACY PLAN — all members not eligible for Medicare are enrolled in this plan as part of your PPO benefits.