



Grievance, Exceptions, Coverage Determinations, and Appeals Process for Part D Prescription Drug Benefits

The following information will explain the rights you have to file a grievance and/or appeal with Network Health Insurance Corporation and the steps to follow as well as the process for exceptions and coverage determinations.

Grievance

If you have a complaint about any aspect of the operations, activities or behavior of Network Health Insurance Corporation (not involving a coverage determination), you have the right to file a grievance.

Examples of reasons to file a grievance:

- Difficulty getting through on the telephone
- Concerns with the quality of services provided
- Interpersonal aspects of care (e.g. rudeness by pharmacist or staff)
- Waiting times when filling a prescription
- Network Health Insurance Corporation's failure to issue a decision in a timely manner

Process

You can submit your grievance orally or in writing within 60 calendar days from the date of the event. We will complete a full investigation as quickly as your case requires and notify you of our investigation results no later than 30 calendar days from the date we received your request. If we need to extend the timeframe to make a determination or we refuse to allow an expedited coverage determination, we will notify you of that extension within 24 hours.

Coverage Determinations and Exceptions

When a request is made regarding payment or benefits, Network Health Insurance Corporation must make a determination to approve or deny the payment or benefit coverage. You may also request that Network Health Insurance Corporation make an Exception to their existing cost-sharing structure or formulary.

There exist two levels of determination: Standard and Expedited. (If you or your physician believes that waiting for a decision under the standard timeframe could place

your life, health, or ability to regain maximum function in serious jeopardy, you or your physician can request an Expedited Coverage Determination.)

Process

Standard Coverage Determination

Once we receive the request, we will notify you of our determination to approve or deny payment or benefit coverage within 72 hours.

If the determination is to deny payment or coverage, we will provide you with a written notice of this determination within three (3) calendar days and include:

- The reason for the denial
- Your right to a standard or expedited appeal and the processes and timeframes
- Your right to provide additional evidence in writing or in person

Expedited Coverage Determination

The request to expedite the coverage determination can be made orally or in writing and if expedited, we will provide a determination no later than 24 hours after receiving the request.

If the determination of the Expedited Coverage Determination is to deny payment or benefit coverage, we will provide you with a written notice of this determination and include:

- The reason for the denial
- Your right to a standard or expedited appeal and the processes and timeframes
- Your right to provide additional evidence in writing or in person

If the request to expedite the Coverage Determination is denied, we will automatically transfer the determination request to the standard timeframe, providing you with prompt oral notification and written notification with three (3) calendar days that includes:

- Our process of automatically transferring the request to the standard timeframe
- Informing you of your right to file an expedited grievance with process and timeframes
- Informing you of your right to resubmit the request for an expedited determination

Appeals

If a Coverage Determination results in an adverse decision (denial of coverage in full or in part) of services you believe you are entitled to receive, you have the right to appeal.

Process

You must submit your request (orally or written) to appeal the decision within 60 calendar days of the notice of the determination and you have the right to present additional information related to your case in writing or in person.

Standard Appeal

We will make a reconsidered determination as quickly as your health condition requires and notify you of the decision no later than seven (7) calendar days from the date the appeal was requested.

If we fail to complete the Standard Appeal within this timeframe, we will forward the complete case file to the independent review entity contracted by CMS within 24 hours of the expiration of the determination timeframe. We will also notify you that your case has been forwarded within this 24 hour timeframe.

Expedited Appeal

If you or your physician believes that waiting for a decision under the standard timeframe could place your life, health, or ability to regain maximum function in serious jeopardy, you or your physician can request an Expedited Appeal orally or in writing.

We will complete the reconsideration and provide notice of the decision as soon as your health condition requires, but no later than 72 hours after receiving the request.

If we fail to complete the Expedited Appeal within this timeframe, we will forward the complete case file to the independent review entity contracted by CMS within 24 hours of the expiration of the determination timeframe. We will also notify you that your case has been forwarded within this 24 hour timeframe.

Second Level Appeal

Following the appeal, if the initial determination is upheld, you have the right to request an appeal by the independent review entity by contacting them in writing within 60 calendar days from the date of the notice of redetermination.

The result of this determination is final and binding.

How to Contact Us

- Phone: (800) 378-5234 or TTY/TDD (800) 947-3529
8 a.m. to 8 p.m., Monday through Friday
- Fax: (920) 720-1908
- Address: Network Health Insurance Corporation, P.O. Box 120, Menasha, WI 54952

Network Health Insurance Corporation is a Medicare Advantage Organization (PPO) with a Medicare Contract.