Member Rights and Responsibilities

How to Reach Experience Health Customer Service

You can reach Experience Health Customer Service daily from 8 a.m. to 8 p.m. at 1-833-777-7394 (TTY: 711). Calls to this number are free.

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. This page explains your Medicare rights and protections as a member of Experience Health Medicare Advantage[SM] (HMO). We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications about your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin or any mental or physical disability you may have.

If you think you have been treated unfairly due to your race, color, national origin, disability, age or religion, please let us know. You can also reach the Office for Civil Rights at 1-833-777-7394 (TTY, 711), or you can contact the regional Office for Civil Rights in your area.

Southern Regional Office for Civil Rights

State in Region	**Contact Information**
North Carolina Alabama Florida Georgia Kentucky Mississippi South Carolina Tennessee	**Phone number:** (800) 368-1019 **TTY number:** (800) 537-7697 (For the hearing and speech impaired) **Address:** Office for Civil Rights U.S. Department of Health and Human Services Atlanta Federal Center Suite 16T70 61 Forsyth Street, SW Atlanta, GA 30303

ATTENTION: If you require language assistance services, these are available to you free of charge. Please use the information listed above to contact Experience Health Customer Service.

Your right to the privacy of your medical records and personal health information

There are Federal and State laws that protect the privacy of your medical records and personal

health information. We keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please use the information listed above to contact Experience Health Customer Service.

Your right to get your prescriptions filled within a reasonable period of time

You should get all of your prescriptions filled from a network pharmacy[1], that is, from pharmacies that contract with Experience Health. You have the right to go to any network pharmacy in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that members have filed against us in the past. To get this information, please use the information listed above to contact Experience Health Customer Service.

Your right to get information about your drug coverage and costs

This website tells you what you have to pay for prescription drugs as a member of Experience

Health. If you need more information, please use the contact numbers listed above to contact Experience Health Customer Service. You have the right to an explanation from us about any bills you may get for drugs not covered by your plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. Learn more about filing an appeal.

Your right to get information about our Plan and our network pharmacies[1]

You have the right to get information from us about the Experience Health Medicare Advantage (HMO) plan. This includes information about our financial condition and about our network pharmacies. To get any of this information, please use the information listed above to contact Experience Health Customer Service.

Your right to disenroll from your plan

You have the right to disenroll from Experience Health during certain periods by giving written notice to Experience Health of your intent to do so. Coverage will end on the last day of the month following the date the Experience Health receives your written request. To end your coverage, you may send written notice to Experience Health, P.O. Box 17468, Winston-Salem, NC 27116. You will receive an acknowledgement of your disenrollment from Experience Health.

How to get more information about your rights

If you have questions or concerns about your rights and protections, use the information listed above to contact Experience Health Customer Service. You can also get free help and information from Seniors' Health Insurance Information Program (SHIIP). You can reach SHIIP at 1-855-408-1212. In addition, the Medicare program has written a booklet called Your Medicare Rights and Protections. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

For concerns or problems related to your Medicare rights and protections described in this section, please use the information listed above to contact Experience Health Customer Service. You can also get help from SHIIP by calling 1-855-408-1212.

What are your responsibilities as a member of Experience Health?

Along with the rights you have as an Experience Health Medicare Advantage (HMO) member, you also have some responsibilities. Your responsibilities include the following:

- Become familiar with your coverage and the rules you must follow to get care as a member. Use the information available on this website as well as other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. If you have questions, use the information listed above to contact Experience Health Customer Service.
- Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.
- Pay your plan premiums and any copayments you may owe for the covered drugs you get.

- Let us know if you have any questions, concerns, problems, or suggestions. If you have questions, use the information listed above to contact Experience Health Customer Service.

30 Day Notice of Formulary Changes

If you are affected by a change in which your drugs are removed from the formulary[1] (no longer covered), or in which your drugs are moved to a tier requiring a higher member copayment, Experience Health Medicare Advantage (HMO) will mail you a notification. This notification will be sent at least 30 days before the formulary change will take effect. The plan will tell you why the change is being made and will list alternative drugs with expected costs.

You are encouraged to use this 30-day time frame to have your drug switched to an appropriate alternative medication. You also have the option to ask Experience Health for a coverage exception.

Please note: Notification about drugs that are removed from the market due to safety reasons or due to the plan's determination that they are non-Part D drugs will not be sent within 30 days of removal from the market.

Experience Health HMO Medical Appeals and Grievances

Grievances

A grievance is a type of complaint that you may file if you are dissatisfied with Experience Health Medicare Advantage (HMO) or with a contracted provider. This type of complaint does not involve coverage or payment disputes. Grievances can include complaints regarding the timeliness, appropriateness, access to, or the quality of your care.

> **Example of a grievance:**
> If you are dissatisfied that you had difficulty getting through to us via the phone lines, then your complaint will be handled as a grievance.

How do I file a grievance?
The grievance must be filed within sixty (60) days after the event or incident that caused you to be dissatisfied. A specific form is not required for you to file a grievance. You or your appointed representative may file a grievance by phone, mail, fax, or in-person.

A Medicare beneficiary may appoint an individual to act as his/her representative in filing a grievance. A representative who is appointed by the court or who is acting in accordance with North Carolina law may also file a grievance. A grievance by a representative is not valid until the Appointment of Representative (AOR) form is completed and submitted, or other equivalent form, legal papers or authority are submitted.

By phone:	By mail:	By fax:	In person:
Experience Health members should call 1-833-777-7394 For the hearing and speech	Experience Health Attn: Medicare Appeal and Grievance Department	Local Number: (336) 794-8836 Toll-Free Number: (888) 375-8836	Experience Health 1965 Ivy Creek Boulevard Durham, NC 27707 **OR**

impaired call 711 (TTY) Seven (7) days a week, 8 a.m. to 8 p.m., Eastern Standard Time	P.O. Box 17509 Winston-Salem, NC 27116-7509		5660 University Parkway Winston-Salem, NC 27105 Mon. - Fri., 8 a.m. - 5 p.m., Eastern Standard Time

If you are dissatisfied with the quality of care you have received, you may also file your grievance with the Quality Improvement Organization (QIO). The Quality Improvement Organization for North Carolina is KEPRO.

You may contact KEPRO:

By phone:	By mail:	By fax:	By website:
1-888-317-0751 or for the hearing and speech impaired call 1-855-843-4776 (TTY/TDD)	5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609	1- 844-878-7921	www.keproqio.com

When will I receive a decision on my grievance?
The resolution of a grievance will be made as quickly as your concern requires, but no more than thirty (30) calendar days after we receive the grievance. We may extend the timeframe by up to fourteen (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. If you request a written response to an oral grievance, one will be provided within thirty (30) days after we receive the grievance. A written response will be provided for all written grievances. Our decision on a grievance is final and is not subject to an appeal.

If we have denied your request for an expedited coverage decision or an expedited appeal or if we have taken a fourteen (14) calendar day extension on the time frame for a coverage decision or appeal, and you disagree with those actions, you may file an expedited or fast grievance. Our response will be provided within twenty-four (24) hours after we receive the grievance.

Please see your Evidence of Coverage for a detailed explanation of the grievance procedures and timeframes for a response. Refer to the Evidence of Coverage for your plan.

- Evidence of Coverage: English | Spanish

Appeals

How do I file an appeal?

Standard Appeals
You can appeal a denied Notice of Denial of Medical Coverage decision, Notice of Denial of Payment decision, or if you are disputing a Copayment or Coinsurance amount you are being billed for, by sending a written, signed request detailing why you think the denial should be overturned. If you cannot file an appeal, you may designate someone, in writing, to file an appeal for you. An Appointment of Representative (AOR) form should be completed and accompany your written

appeal. Your physician can also file an appeal of a Notice of Denial of Medical Coverage decision for you without being your appointed representative.

An appeal must be filed within sixty (60) calendar days of the denial notice that we sent to you. You may file your appeal by:

By mail:	By fax:	In person:
Experience Health Attn: Medicare Appeal and Grievance Department P.O. Box 17509 Winston-Salem, NC 27116-7509	Local Number: (336) 794-8836 Toll-Free Number: (888) 375-8836	Experience Health 1965 Ivy Creek Boulevard Durham, NC 27707 **OR** 5660 University Parkway Winston-Salem, NC 27105 Mon. - Fri., 8 a.m. - 5 p.m., Eastern Standard Time

We will investigate your concern(s) and respond to you in writing. Our response to a standard appeal of a Notice of Denial of Medical Coverage will be sent within thirty (30) calendar days of the Plan's receipt of the appeal, or within forty-four (44) calendar days if an extension was taken. Our response to an appeal of a Notice of Denial of Payment will be sent within sixty (60) calendar days of the Plan's receipt of the appeal.

Expedited or Fast Appeals
If you or your doctor believes that waiting on a standard appeal decision on a Notice of Denial of Medical Coverage could seriously harm your health or your ability to function, you, your authorized representative or your doctor can ask for an expedited or fast appeal. Note: An appeal request for a Notice of Denial of Payment or Copayment or Coinsurance dispute cannot be expedited.

To file an Expedited or Fast appeal:

By phone:	By mail:	By fax:	In person:
Experience Health members should call 1-833-777-7394 For the hearing and speech impaired call 711 (TTY) Seven (7) days a week, 8 a.m. to 8 p.m., Eastern Standard Time	Experience Health Attn: Medicare Appeal and Grievance Department P.O. Box 17509 Winston-Salem, NC 27116-7509	Local Number: (336) 794-8836 Toll-Free Number: (888) 375-8836	Experience Health 1965 Ivy Creek Boulevard Durham, NC 27707 **OR** 5660 University Parkway Winston-Salem, NC 27105 Mon. - Fri., 8 a.m. - 5 p.m.,

If calling after business hours, just follow the prompts to file an expedited or fast appeal.			Eastern Standard Time

When will I receive a decision on my appeal?
We will respond by phone and in writing to an expedited appeal within seventy-two (72) hours of our receipt of the expedited or fast appeal request. If someone other than you or your physician decides to file an expedited or fast appeal for you, an Appointment of Representative (AOR) form must be received before the appeal review can begin.

We may extend the timeframe by up to fourteen (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.

Appealing an Important Message Notification for Your Hospital Discharge
If you receive an Important Message from Medicare About Your Rights for your inpatient hospital services from the provider and you want your inpatient hospital services to be covered longer, you are entitled to file an appeal with the Quality Improvement Organization (QIO), rather than Experience Health. Please follow the instructions contained in the Important Message for the steps to follow to file an appeal with the QIO.

Appealing a Notice of Medicare Non-Coverage
If you receive an advance Notice of Medicare Non-Coverage for skilled nursing, home health or comprehensive outpatient rehabilitation services from the provider of the service, you are entitled to file an appeal with the Quality Improvement Organization (QIO), rather than Experience Health, regarding the upcoming termination of services. Please follow the instructions contained in the Notice for the steps to follow to file an appeal with the QIO.

Please see your Evidence of Coverage for a detailed explanation of the appeals and grievance procedures and timeframes for a response. Refer to the Evidence of Coverage for your plan.
To obtain an aggregate number of Medicare Advantage Plan appeals and quality of care grievances, you may call Customer Service at 1-833-777-7394 (toll-free) for Experience Health (TTY, 711), seven (7) days a week, 8 a.m. to 8 p.m. Eastern Standard Time

You can also file a complaint with Medicare here:

- Medicare Complaint Form

Appeals and Grievance Procedures for Prescription Drugs

Grievances

A grievance is a type of complaint that you may file if you are dissatisfied with Experience Health Medicare Advantage[SM] (HMO), with one of our network pharmacies[1], or one our contracted providers. This type of complaint does not involve coverage or payment disputes. Grievances can include complaints regarding the timeliness, appropriateness, access to, or setting of a covered prescription drug or the quality of your care.

Example of a grievance:
If you are dissatisfied that we have removed a drug from our formulary,

but you are not asking the Plan to approve coverage of the drug for you, then your complaint will be handled as a grievance.

If you are dissatisfied with the quality of care you have received, you may also file your grievance with the Quality Improvement Organization (QIO). The Quality Improvement Organization for North Carolina is KEPRO.

You may contact KEPRO:

By phone:	By mail:	By fax:	By website:
1-888-317-0751 or for the hearing and speech impaired call 1-855-843-4776 (TTY/TDD)	5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609	1-833-868-4058	www.keproqio.com

How do I file a grievance?
The grievance must be filed within sixty (60) days after the event or incident that caused you to be dissatisfied. A specific form is not required for you to file a grievance. You or your appointed representative may file a grievance by phone, mail, fax, or in-person.

By phone:	By mail:	By fax:	In person:
Experience Health members should call 1-833-777-7394 For the hearing and speech impaired call 711 (TTY) Seven (7) days a week, 8 a.m. to 8 p.m., Eastern Standard Time	Experience Health Attn: Medicare Appeal and Grievance Department P.O. Box 17509 Winston-Salem, NC 27116-7509	Local Number: (336) 794-8836 Toll-Free Number: (888) 375-8836	Experience Health 1965 Ivy Creek Boulevard Durham, NC 27707 **OR** 5660 University Parkway Winston-Salem, NC 27105 Mon. - Fri., 8 a.m. - 5 p.m., Eastern Standard Time

When will I receive a decision on my grievance?
The resolution of a grievance will be made as quickly as your concern requires, but no more than thirty (30) calendar days after we receive the grievance. We may extend the timeframe by up to fourteen (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. If you request a written response to an oral grievance, one will be provided within thirty (30) days after we receive the grievance. A written response will be provided for all written grievances. Our decision on a grievance is final and is not subject to an appeal.

You have the right to an expedited review of a grievance concerning our refusal to grant an expedited coverage determination or expedited appeal. This type of grievance will be responded to within twenty-four (24) hours after we receive the grievance.

Appointing a representative
A Medicare beneficiary may appoint an individual to act as his/her representative in filing a

grievance. A representative who is appointed by the court or who is acting in accordance with North Carolina law may also file a grievance. A grievance by a representative is not valid until the Appointment of Representative (AOR) form is completed and submitted, or other equivalent form, legal papers or authority are submitted.

Please see your Evidence of Coverage for a detailed explanation of the grievance procedures and timeframes for a response. Refer to the Evidence of Coverage for your plan.

You can also file a complaint with Medicare here:

- Medicare Complaint Form

Appeals

An appeal is your opportunity to request a redetermination of an adverse coverage determination, which includes denied exception requests.

> **Example of an appeal:**
> If we deny your request for an exception to cover a non-formulary drug, then you may file an appeal of the denial. An appeal can only be filed after an exception has been requested and denied by the Plan.

How do I file an appeal?

If you receive a coverage determination denial, you or your appointed representative or your prescriber may file an appeal. An appeal must be filed within sixty (60) calendar days of the date of the denial notice and must be in writing, unless you are filing an expedited or fast appeal. You may file your appeal by:

By mail:	By fax:	In person:	Email:
Experience Health Attn: Medicare Park D Appeals P.O. Box 17509 Winston-Salem, NC 27116-7509	(336) 794-8836 (888) 375-8836	Experience Health 1965 Ivy Creek Boulevard Durham, NC 27707 OR 5660 University Parkway Winston-Salem, NC 27105 Mon. - Fri., 8 a.m. - 5 p.m., Eastern Standard Time	Send Part D appeal emails to: PartDAppeals@experiencehealthnc.com A Part D appeal by email must include the member's: • Full name • Member ID number (see your member ID card) • Date of birth • Phone number • The name of the drug for which the appeal is being requested • The name and telephone number of the person who prescribed the drug • The reason you think the drug should be covered

Note: A specific form is not required for you to file an appeal; however, a form is available for your use by clicking on the link below. Completion of this form may help you with your review request and assist us in the review process.

- Part D Appeal Form

When will I receive a decision on my appeal?

Standard Appeals
We will perform a standard review of your appeal as soon as your health requires but no later than seven (7) calendar days after we receive your appeal. You will receive a written response to your appeal.

Expedited or Fast Appeals
We will review requests for an expedited or fast appeal as soon as possible, but no later than seventy-two (72) hours following our receipt of the request. The decision on an expedited appeal will be provided by phone followed by the written notice.

An individual who was not involved with your original coverage determination will make a decision on your appeal.

If our decision is to deny the appeal, the notice will advise you of your right to submit your appeal to the Independent Review Entity (IRE) with instructions on how to do so. If we miss our timeframes for claims adjudication or review of the appeal, we will automatically forward the appeal to the IRE for a decision. There may be additional levels of appeal available to you. We will inform you of your additional rights in the notice, or you may refer to your Evidence of Coverage for further details.

Appointing a representative
A Medicare beneficiary may appoint an individual to act as his/her representative in filing an appeal. A representative who is appointed by the court or who is acting in accordance with North Carolina law may also file an appeal. An appeal by a representative is not valid until the Appointment of Representative (AOR) form is completed and submitted, or other equivalent form, legal papers or authority are submitted.

Please see your Evidence of Coverage for a detailed explanation of the appeals procedures and timeframes for a response. Refer to the Evidence of Coverage for your plan.

You can also file a complaint with Medicare here:

- Medicare Complaint Form

Transition Process for Prescription Drugs

This policy describes the transition requirements published by the Centers for Medicare and Medicaid Services (CMS) which state that all Part D sponsors must provide an appropriate transition benefit for members.

This policy covers the following:

- Eligible members
- Applicable drugs
- New prescriptions versus ongoing drug therapy
- Transition time frames
- Transition extensions
- Transition across contract years for current members
- Emergency supply for current members
- Treatment of re-enrolled members

- Level of care changes
- Transition notices

This policy describes how transition benefits apply when you are filling prescriptions in:

- Long Term Care (LTC) settings
- Retail pharmacies
- Extended Supply Network (ESN) (90 days of retail setting)
- Mail Order pharmacies

Eligible Members

If you are currently taking drugs that are not included in your plan's new formulary1 (drug list) from one year to the next, you may be eligible for a transition supply if you are:

- New to the prescription drug plan at the start of 2020
- Newly eligible for Medicare Part D in 2020
- Switching from one Medicare Part D plan to another after January 1st, 2020
- Affected by negative changes to the plan's drug list from 2019 to 2020
- Living in an LTC setting

Applicable drugs

The transition benefits allows members to receive a supply of eligible Part D drugs when the drugs are:

- Not on your plan's list
- Previously approved for coverage under an exception once the exception expires
- On your plan's drug list but your ability to get the drug is limited
    - For example, under a Utilization Management (UM) program that require:
        - Prior Authorization (PA)
        - Step Therapy (ST)
        - Quantity Limits (QL)

You may be eligible for a transition supply of a drug in order to meet your immediate needs. This is meant to allow enough time for you to work with your doctor to find a similar drug on the plan's drug list that will meet your medical needs or to complete a coverage determination to continue coverage of a drug you are currently taking based on medical necessity. An approved coverage determination request may allow continued coverage of a drug you are currently taking.

Certain drugs may not be eligible for a transition supply at the pharmacy; these drugs first require a review to determine if they can be covered by your Part D plan.

If you or your doctor want to request a coverage determination, the forms are available by mail, fax, email, and on our website; you can access the forms yourself or request a form be sent to you and/or your doctor. The plan reviews coverage determination requests and will notify you once a decision is made. If the plan does not approve the request, you will be provided with additional information regarding your options.

You may qualify for refills of transition supplies that are dispensed for less than the written amount due to quantity limits, which may be used for safety purposes.

New prescriptions versus ongoing drug therapy

Transition benefits are applied at the pharmacy to new prescriptions when it is not clear if a

prescription is for a drug you are taking for the first time or an ongoing prescription for a drug that is not on your plan's drug list.

Transitions time frames

In outpatient settings (retail, ESN and mail order)
If you are new or re-enrolled to the plan, you may be allowed a 30-day transition supply of eligible Part D drugs (unless the prescription is written for a fewer days) any time during your first 90 days of coverage.

In LTC settings
You may be allowed a 31-day transition supply (unless the prescription is written for fewer days) of eligible Part D drugs during the first 90 days of coverage. After the 90-day transition period has ended, if a coverage determination request is being processed you may be able get an emergency 31-day supply.

Transition extension

The transition period may be extended on a case-by-case basis if the review of a coverage determination request or an appeal has not been processed by the end of your minimum transition period (first 90 days of coverage). The extension is then provided only until you have switched to a drug on the plan's drug list or a decision on the coverage determination request or appeal is made.

Transition across contract years for current members

If you have not switched to a covered drug prior to the new calendar year, a transition supply may be provided if the following has occurred:

- Your drugs are removed from the plan's drug list from 2020 to 2021
- New UM requirements are added to your drugs from 2020 to 2021

If you are an existing member with recent history of using a drug which is not covered by your plan or you have limited ability to get the drug:

- In a retail setting you may get a 30-day transition supply (unless the prescription is written for fewer days) any time during the first 90 days of the calendar year
- In a LTC setting you may get a 31 day transition supply any time during the first 90 days of the calendar year.

This policy is in place even if you enroll with a start date of either November 1 or December 1 and need a transition supply.

Emergency supply for current members

If you are in a LTC setting, you may be allowed a 31-day emergency supply as part of the transition process, unless the prescription is written for fewer days, of a drug that is not on the drug list, or your ability to get the drug is limited. In the event that a coverage determination request is still being processed after the 90-day period, you may be able to get an emergency supply. Your LTC pharmacy can call to see if your fill qualifies as an emergency supply.

Treatment of re-enrolled members

You may leave one plan, enroll in another plan, and then re-enroll in the original plan. If this happens, you will be treated as a new member so you are eligible for transition benefits. The transition benefits begin when you re-enroll in your original plan.

Level of care changes

You may have changes that take you from one level of care setting to another. During this level of care change, drugs may be prescribed that are not covered by your plan. If this happens, you and your doctor must use your plan's coverage determination request process.

To prevent a gap in care when you are discharged, you may get a full outpatient supply that will allow therapy to continue once the limited discharge supply is gone. This outpatient supply is available before discharge from a Medicare Part A stay.

When you are admitted to or discharged from an LTC setting, you may not have access to the drugs you were previously given. However, you may get a refill upon admission or discharge.

Transition notices

When you or your pharmacy submit a prescription drug claim for a transition supply, a letter is sent to you by first class U.S. mail within three business days of the date your drug claim is submitted. Efforts are made to notify doctors when a prescription they write for a member results in a transition supply. This letter is sent to explain the following information:

- That the transition supply is temporary and may not be refilled unless a coverage determination request is approved
- That you should work with your doctor to find a new drug option that is on your plan's drug list
- That you can request a coverage determination and how to make the request, timeframes for processing requests, and the appeal rights if the coverage determination is not approved

Cost considerations

You will be charged the cost share amount for a transition supply of drugs provided, as follows:

- For low income subsidy (LIS) members, you will not be charged a higher cost sharing for transition supplies than the statutory maximum copayment amounts.
- For non-LIS enrollees, you will be charged:
    - The same cost share amount for Part D drugs that are not on the drug list that you would be charged for drugs approved through a formulary exception; or
    - The same cost share amount for drugs on the drug list with UM edits that would apply if the UM criteria are met.

For questions about this policy please call the phone number on the back of your Member ID card.

Coverage Determination for Prescription Drugs

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. (Please, also see the description of the exceptions process.) You must contact us if you would like to request Experience Health Medicare Advantage[SM] (HMO) coverage determination, including an exception. You cannot request an appeal if we have not issued a coverage determination.

The following are examples of when you may ask Experience Health for a coverage determination:

- If you are not getting a prescription drug that you believe Experience Health covers
- If you received a Part D prescription drug that you believe Experience Health covered while you were a member, but the plan refused to pay for the drug.

- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped and that you believe you have extenuating circumstances that should exclude you from the reduction/non-coverage
- If there is a limit on the quantity (or dose) of the drug, and you disagree with the requirement or dosage limitation
- If you bought a drug at a pharmacy that is not in the network and you want to request reimbursement for the expense

How do I make a request for a coverage determination?
To ask for a standard decision, you or your appointed representative may call Customer Service toll free, 7 days a week, 8 a.m. to 8 p.m. at 1-833-777-7394 (TTY: 711)

You can also deliver a written request to Experience Health at:

1965 Ivy Creek Boulevard
Durham, NC 27707

OR

5660 University Parkway
Winston-Salem, NC 27105
Mon. - Fri., 8 a.m. - 5 p.m. Eastern Standard Time

You may fax your request to 1-888-446-8535.

To ask for a fast decision, you, your physician, or your appointed representative may contact us using the above information. After regular business hours, you should consult with a network pharmacy regarding your need for an emergency or temporary supply of medication until you can contact the Plan the next business day. Be sure to ask for a "fast," "expedited," or "24-hour" review. NOTE: You cannot ask for a fast decision on a request for coverage of a drug already purchased.

By Email
An email request for coverage determination or Part D exception must include the member's:
- Full name
- Member ID number (see your member ID card)
- Date of birth
- Phone number

AND
- The name of the drug for which the coverage determination or Part D exception is being requested
- The name and telephone number of the person who prescribed the drug

To request for a Prescription Drug Coverage Determination requiring authorization such as Non Formulary, Prior Authorization, Quantity Limits, Tier Exceptions, or Step Therapy, please send your email to: PartDExceptions@experiencehealthnc.com

Forms may be submitted to this email address or mailed to the address located on the form.
- Coverage Determination Form

To request reimbursement of a Prescription Drug for purchases you have already made, please

send your email to: PartDClaims@experiencehealthnc.com

Forms may be submitted to this email address or mailed to the address located on the form.

- Prescription Drug Claim Form

When will I hear back with a decision?
Generally, we must make our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. If your request involves a request for an exception (including a formulary exception or an exception from utilization management rules, such as dosage or quantity limits), 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.

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." Requests for reimbursement of prescriptions you have already purchased are responded to with 14 days after we have received the request.

Exceptions are part of the coverage determination process. You, your authorized representative, or your prescribing physician may request an exception to seek coverage of a drug that:

- Is not on the formulary
- Requires prior authorization
- Has quantity limitations

Example of an exception request: If the Plan's formulary does not include a drug that you or your prescribing physician feel is necessary, then you or your prescribing physician may request an exception so that you may obtain coverage of this drug. If the Plan does not grant the requested exception, then you or your prescribing physician may file an appeal.

How do I make an exception request?
You or your prescribing physician may request an exception to the coverage rules for your Medicare prescription drug plan:

By phone:	By mail:
Experience Health members should call 1-833-777-7394 (TTY: 711) Seven (7) days a week 8 a.m. to 8 p.m. Eastern Standard Time Physicians should call: 1-877-397-4584	Attn: Rx Coverage Determination P.O. Box 17509 Winston-Salem, NC 27116-7509

A specific form is not required for you to make an exception request, although there are Experience Health forms available to you and your physician to request an exception or prior approval for a drug. The request must include your prescribing physician's statement that he/she has determined that the preferred drug either would not be as effective for you and/or would have adverse effects for you.

When will I receive a decision on my exception request?
We will review the exception request and notify both you and your prescribing physician of our decision as soon as your health requires, but no later than 72 hours from the time we receive your physician's supporting statement. Faster exception decisions are available if this 72-hour time frame could seriously harm your health or ability to function.

If the decision is not in your favor, the notice will be given by phone followed by a written notice within three business days. The notice will tell you how to pursue your appeal rights if you are dissatisfied with our decision.

Organization Determinations for Medical Services by Care Management

Experience Health Medicare Advantage (HMO) Care Management
When we make an organization determination, we are making a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called 'coverage decisions' in your Evidence of Coverage (EOC).

Prior Plan Approval

Certain services need prior approval for payment by the plan. Your evidence of coverage (EOC) provides explanation of what services require prior approval.

Prior Approval means we review the information before the service occurs. Information needed for these reviews includes the name of your ordering physician, the name of the provider of service, the type of service(s) needed and any supporting medical information.

How do I request coverage for a service that requires prior approval?
You or your physician may contact the Plan by fax, phone, mail or in-person to request prior approval for a service. You may also appoint an individual to act as your representative in filing a request for prior approval. A representative who is appointed by the court or who is acting in accordance with North Carolina law may also file a request for prior approval for you.

A request by your representative is not valid until the Appointment of Representative (AOR) form, or other equivalent form, legal papers or authority is submitted to the Plan.

By fax:	By phone:	By mail:	In person:
Utilization Management: 1-336-794-8836 or 1-888-375-8836 If submitting by fax, provide the following: • Name • Plan ID number	Experience Health Utilization Management: 1-833-941-0107 Monday - Friday, 8 am - 6 pm, Eastern Standard Time Closed on Thanksgiving	Experience Health Attn: Medicare Appeal and Grievance Department P.O. Box 17509 Winston-Salem, NC 27116-7509	Experience Health 1965 Ivy Creek Boulevard Durham, NC 27707 OR 5660 University Parkway

• Date of Birth	and Christmas By phone for Hearing and Speech Impaired: 1-833-777-7394, TTY is 711 Seven (7) days a week, 8 a.m. to 8 p.m., Eastern Standard Time		Winston-Salem, NC 27105 Mon. - Fri., 8 a.m. - 5 p.m., Eastern Standard Time

When will I receive a decision on my request for prior plan approval?
The prior approval review will be made as quickly as possible once all of the necessary medical information is received.

- The timeframe for a standard request is no more than fourteen (14) calendar days.
- The timeframe for an expedited request is seventy-two (72) hours.
- We may extend the timeframe by up to fourteen (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.

You will receive a written response when a decision is made.

Appeals

How do I file an appeal?

Standard Appeals
You can appeal a denied Notice of Denial of Medical Coverage decision, Notice of Denial of Payment decision, or if you are disputing a Copayment or Coinsurance amount you are being billed for, by sending a written, signed request detailing why you think the denial should be overturned. If you cannot file an appeal, you may designate someone, in writing, to file an appeal for you. An Appointment of Representative (AOR) form should be completed and accompany your written appeal. Your physician can also file an appeal of a Notice of Denial of Medical Coverage decision for you without being your appointed representative.

An appeal must be filed within sixty (60) calendar days of the denial notice that we sent to you. You may file your appeal by:

By mail:	By fax:	In person:
Experience Health Attn: Medicare Appeal and Grievance Department P.O. Box 17509 Winston-Salem, NC 27116-7509	(336) 794-8836 (888) 375-8836	Experience Health 1965 Ivy Creek Boulevard, Durham, NC 27707 or 5660 University Parkway, Winston-Salem, NC 27105 Mon. - Fri., 8 a.m. - 5 p.m., Eastern Standard Time

We will investigate your concern(s) and respond to you in writing. Our response to a standard appeal of a Notice of Denial of Medical Coverage will be sent within thirty (30) calendar days of the Plan's receipt of the appeal, or within forty-four (44) calendar days if an extension was taken. Our response to an appeal of a Notice of Denial of Payment will be sent within sixty (60) calendar days of the Plan's receipt of the appeal.

Expedited or Fast Appeals

If you or your doctor believes that waiting on a standard appeal decision on a Notice of Denial of Medical Coverage could seriously harm your health or your ability to function, you, your authorized representative or your doctor can ask for an expedited or fast appeal.

Note: An appeal request for a Notice of Denial of Payment or Copayment or Coinsurance dispute cannot be expedited.

To file an Expedited or Fast appeal:

By phone:	By mail:	By fax:	In person:
Experience Health members should call 1-833-777-7394, for the hearing and speech impaired call 711 (TTY) Seven (7) days a week, 8 a.m. to 8 p.m., Eastern Standard Time If calling after business hours, just follow the prompts to file an expedited or fast appeal.	Experience Health Attn: Medicare Appeal and Grievance Department P.O. Box 17509 Winston-Salem, NC 27116-7509	(336) 794-8836 (888) 375-8836	Experience Health 1965 Ivy Creek Boulevard, Durham, NC 27707 or 5660 University Parkway, Winston-Salem, NC 27105 Mon. - Fri., 8 a.m. - 5 p.m., Eastern Standard Time

When will I receive a decision on my appeal?

We will respond by phone and in writing to an expedited appeal within seventy-two (72) hours of our receipt of the expedited or fast appeal request. If someone other than you or your physician decides to file an expedited or fast appeal for you, an Appointment of Representative (AOR) form must be received before the appeal review can begin.

We may extend the timeframe by up to fourteen (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.

Appealing an Important Message Notification for Your Hospital Discharge

If you receive an Important Message from Medicare About Your Rights for your inpatient hospital services from the provider and you want your inpatient hospital services to be covered longer, you are entitled to file an appeal with the Quality Improvement Organization (QIO), rather than Experience Health. Please follow the instructions contained in the Important Message for the steps to follow to file an appeal with the QIO.

Appealing a Notice of Medicare Non-Coverage

If you receive an advance Notice of Medicare Non-Coverage for skilled nursing, home health or comprehensive outpatient rehabilitation services from the provider of the service, you are entitled

to file an appeal with the Quality Improvement Organization (QIO), rather than Experience Health, regarding the upcoming termination of services. Please follow the instructions contained in the Notice for the steps to follow to file an appeal with the QIO.

Please see your Evidence of Coverage for a detailed explanation of the appeals and grievance procedures and timeframes for a response. Refer to the Evidence of Coverage for your plan.
To obtain an aggregate number of Medicare Advantage Plan appeals and quality of care grievances, you may call Customer Service at 1-833-777-7394 (toll-free) for Experience Health (TTY, 711), seven (7) days a week, 8 a.m. to 8 p.m. Eastern Standard Time.

Quality Assurance

How is Quality Assurance defined?
Quality Assurance includes the processes and systems put in place to evaluate prescriptions for health and safety issues. They help promote the appropriate use of medications by improving compliance and reducing medication errors and adverse drug interactions.

Quality Assurance programs

Quality assurance processes for Experience Health Medicare Advantage (HMO) are summarized below:

Concurrent Drug Utilization Review (DUR):

This occurs while a claim is being processed at the pharmacy. Prescriptions are screened for the following safety issues and the pharmacist is sent a message immediately, alerting them of the potential issue.

- **Drug Interactions:** Instances when the prescribed drug can potentially result in ineffective or unsafe treatment when used in combination with another drug
- **Drug-Allergy:** Identifies when the prescribed drug may potentially cause problems based on patient's reported allergies.
- **Drug-Disease:** Instances when the prescribed drug may potentially worsen the patient's reported medical condition(s).
- **Drug-Gender Contraindications:** Identifies prescription medications being inappropriately filled based on patient gender
- **Drug-Age:** Identifies those drugs that are contraindicated for use by older adults.
- **Excessive Daily Dosing and Duration of Therapy:** Identifies when a prescription claim is being filled for more than the recommended maximum daily dose or duration.
- **Refill Too Soon or Too Late:** Identifies patients who may not be taking their medication as prescribed by their physician.
- **Therapy Duplication:** Identifies when the prescription being filled is from the same Therapeutic Class as other medications in the members profile.
- **Potential Drug Name Confusion:** Identifies prescriptions that sound alike, or when written, look alike.

Retrospective Drug Utilization Review (DUR):

This occurs after the prescription has been dispensed. It is a program that evaluates a members' drug history to identify prescribing issues. Alerts are provided by mail to physicians, addressing prescribing practices and uses that are unsafe, ineffective, or otherwise inconsistent with evidence-based standards of care.
Retrospective DUR complements the Concurrent DUR program by identifying physicians who for some reason may be resistant to the messages generated by concurrent monitoring.
The Retrospective DUR health and safety alerts are made up of four key categories:

- **Potential Drug-Drug Interactions:** Instances when prescribed medications can potentially result in ineffective or unsafe treatment when used in combination with another drug.
- **Dose Considerations with Pain Medications:** Examines the use of certain high dose pain medications
- **Drug Age Considerations:** Considers the adverse effects of certain drugs or drug classes on the elderly population.
- **Therapy Duplication:** Identifies the use of two or more drugs in the same therapeutic class that may put the patient at risk of additional unwanted side effects or adverse medical event.

Refill Reminders to Patients: As part of the dispensing process, a refill notice is generated by computer and included with each dispensed mail-order prescription. The email refill reminder program is designed to remind plan members to refill and continue to take important medications, specifically those medications that are for chronic conditions for which there may not always be signs and symptoms of illness.

Notice of Possible Contract Termination

Experience Health has a contract with the Centers for Medicare & Medicaid Services (CMS) to provide a Medicare Advantage prescription drug plan (MAPD). Experience Health is also a Medicare-approved Part D sponsor. CMS is the government agency that runs Medicare. This contract renews each calendar year. Each year the contract is reviewed, and either Experience Health or CMS can decide to end it. Members will get 90 days advance, written notice if the contract will not be renewed in this situation. It is also possible for our contract to end at some other time. If the contract is going to end, we will generally tell members 90 days in advance. Advance notice may be as little as 30 days or even fewer days if CMS ends our contract in the middle of the year. In this notice, we would provide a written description of alternatives available for obtaining qualified prescription drug coverage in North Carolina. We are also required to notify the general public of a contract termination via local newspapers.

If Experience Health decides to stop offering Experience Health Medicare Advantage[SM] (HMO), or change the service area so that it no longer includes the area where you live, membership in Experience Health affected by that change will end for everyone in the affected plan within that service area, and members will have to change to a different Medicare Advantage or Medicare drug plan, return to Original Medicare or select a Medicare Supplement plan, if needed. Experience Health will provide coverage until the contract ends.

Out of Network Coverage for Prescription Drugs

How is out-of-network defined?
Generally the term Out-of-network refers to the use of providers that are not contracted to provide services to Experience Health members. In some situations, the use of out-of-network providers is permissible. There are several specific situations in which coverage may be available out-of-network[1]:

- You are in an emergency situation and need access to a covered Part D drug;
- You are traveling outside of the service area; run out of or lose the covered drug(s)or become ill and need a covered drug and cannot access a network pharmacy;
- You cannot obtain a covered drug in a timely manner within your service area, because for example, there is no network pharmacy within a reasonable driving distance that provides 24-hour-a-day/7-day-per-week service;

- You reside in a long term care facility and the contracted long term care pharmacy does not participate in the plan's pharmacy network;
- You must fill a prescription for a covered drug, and that particular drug is not regularly stocked at accessible network retail or mail-order pharmacies (for example, an orphan drug or other specialty pharmaceutical typically shipped directly from manufacturers or special vendors).
- You are evacuated or displaced from your residence due to a state or federally declared disaster or health emergency.

What is excluded from out-of-network coverage?
Routine use of an OON pharmacy is not permitted by a member who resides in a location where adequate pharmacy access exists (please refer to the pharmacy access standards). Members are encouraged to use network pharmacies unless one of the specific OON situations listed above applies.[1]

In the situations listed above, will I have prescription drug coverage?
Yes, we will pay up to our allowed amount for the drug minus any applicable copay or coinsurance.

What do I need to do if I need to get a prescription drug at an out-of-network retail pharmacy?[1]
For one of the out-of-network situations described above, you will need to do the following:
- Pay full charges at the non-network pharmacy.
- File the claim via paper claim form for reimbursement.

What will I be reimbursed?
There are two reimbursement scenarios for the out-of-network benefit. These are:
- If you live in a county that does not have adequate access to a participating pharmacy - in this situation, after you submit your paper claim, you will be reimbursed up to the plan's allowed amount minus your cost share.[1]
- If you live in a county with adequate access to a participating pharmacy - if you use an out-of-network (or non-participating) pharmacy in counties with adequate access, you will be reimbursed up to the plan's allowed amount minus your cost share. You must meet one of the five allowable circumstances outlined above. Routine use of an out-of-network pharmacy will require that you pay 100% of the charges.[1]

Please note that in emergency situations, you will be reimbursed the entire amount minus your member cost share amount.

What are the pharmacy access standards?
Medicare categorizes the pharmacy access standards into three categories: urban, suburban and rural. These access standards vary based upon locale as listed below.
- Urban - On average, 90% of members who live in an urban area have access to a retail network pharmacy within 2 miles of their residence;
- Suburban - On average, 90% members who live in an suburban area have access to a retail network pharmacy within 5 miles of their residence; and
- Rural - At least 70% of members, on average, have access to a retail network pharmacy within 15 miles of their residence.

How do I know if there is a pharmacy that meets the access standards for where I live?
You can either call the Customer Service number on the back of your ID card and ask the

representative, or search our online pharmacy directory.[1]

What drugs and vaccines are generally dispensed and administered in the physician office setting?
Certain drugs and vaccines not covered under Medicare Part B may be covered by Experience Health Medicare Advantage (HMO). In many cases these drugs and vaccines will require prior approval to be requested and approved before coverage can be provided under the Experience Health Medicare Advantage (HMO) benefit.

Prescription by Mail

The Experience Health mail order prescription program is provided through AllianceRx Walgreens Prime, which offers you the convenience of receiving up to a 90-day supply of medication delivered to you with free standard shipping. Typically, you should expect to receive your prescription drugs within five to eight days from the time that the mail order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact us at the number listed below.

If your member ID card has Prime Therapeutics on the back, you are eligible for this benefit.

What You Get
With Alliance Rx Walgreens Prime, you get the convenience of having your long-term prescription medications delivered right to your door plus many other features.

- Free standard shipping
- Ability to order prescriptions either online, over the phone or through the mail
- Ability to check your order status online
- View your prescription history
- Member service agents available 24/7

You should continue to get your short-term prescriptions, such as antibiotics, from your local pharmacy where you may pay less if you only need a one-month supply.

Getting Started
Register with AllianceRx Walgreens Prime Mail
To receive your medications from AllianceRx Walgreens Prime Mail, you must first register. It's fast and easy to register with AllianceRx Walgreens Prime Mail. There are three convenient options.

- **Online –** Register online by going to AllianceRx Walgreens Prime Mail
- **Telephone –** Call AllianceRx Walgreens Prime Mail at 1-877-277-5457 (TTY users 711) and a member service representative will help get you started.
- **Mail –** Complete the refill or new prescription order form and mail to

  AllianceRx Walgreens Prime Mail
  PO Box 29061
  Phoenix, AZ 85038-9061

Send in Your Prescription
Once you are registered, AllianceRx Walgreens Prime Mail will need your prescription. You can mail your prescription to AllianceRx Walgreens Prime Mail, or have your doctor submit it by phone, fax, or electronically.

- **Mail -** If you have a written prescription from your doctor, you can mail it with a completed refill or new prescription order form and your applicable mail copayment to:

  AllianceRx Walgreens Prime Mail
  PO Box 29061
  Phoenix, AZ 85038-9061

Submitting A Claim (member-submitted)

How do I file a medical claim?

Experience Health network Providers will file claims for services rendered. Members should not have to file a claim for services rendered by in network Providers. If you are asked to file a claim, by a Provider who is in the Experience Health network, please call customer service at 1-833-777-7394 (TTY: 711) Monday thru Friday, 8am to 8pm Eastern Time, for assistance.

If you visit a Provider who is not in the Experience Health network, you may have to pay for the service and file a claim directly to Experience Health for reimbursement. We do not require out of network Providers to submit claims.

To file a claim:

- Complete the Member Submitted Claim Form
- Enclose documentation (a copy of your bill) and proof of payment
- Write your member ID on all documentation
- Mail to:

  Experience Health
  Attention: Claims Dept.
  PO Box 17509
  Winston-Salem, NC 27116-7509

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[1] Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Experience Health is an HMO plan with a Medicare contract. Enrollment in Experience Health depends on contract renewal. BLUE CROSS®, BLUE SHIELD®, the Cross and Shield Symbols and service marks are marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Experience Health is an independent licensee of the Blue Cross and Blue Shield Association, serving North Carolina.

This information is current as of 10/01/2020