2. Complaints and Appeals

Members who do not agree with the PBM's determination regarding a prior authorization request, the dispensing of a brand drug, the payment of a claim or any other drug benefit determination, may appeal the decision by calling the phone number on the pharmacy ID card or by writing to the address specified in the section of this document entitled "Plan Information, Addresses and Phone Numbers" within 180 days of the decision.

The pharmacy Benefit has a two-level appeal process. The first level of appeal is handled by the PBM. If a Member receives a determination on a prior authorization request with which he/she does not agree and submits an appeal, a decision will be rendered within 72 hours if all information necessary to make a decision has been provided to the PBM. If a Member pays for a prescription (either in whole or in part) and appeals the PBM's payment or lack thereof, he/she will usually receive a determination within 30 days.

If a Member does not agree with the PBM's decision regarding a Level One Appeal, he/she may initiate a Level Two Appeal within 90 days after receipt of a Level One Appeal denial notice. Detailed information regarding the Second Level Appeal process is provided to the Member by the PBM upon delivery of the First Level Appeal decision. The Second Level Appeal is performed by an independent review organization. As with the First Level Appeal process, decisions regarding urgent care Appeals are rendered within 72 hours of receipt of the information necessary to render a decision, decisions regarding non-urgent prior authorization requests are rendered within 15 days of receipt of necessary information, and decisions regarding payments made by the Plan are usually rendered within 30 days of receipt of the Appeal and the information necessary to render a decision. If information necessary to render a decision is not provided, a decision will be made with the information available to the independent review organization.

When pursuing an authorization or payment denial, a Member is entitled to receive any guidelines, rules or protocols relied upon in making the decision and all documents, records and other information relevant to the determination, without regard to whether this information was relied upon in making the determination.

D. State of Vermont External Appeal Process – Vermont Department of Financial Regulation

In addition to the appeals processes outlined above for medical care, mental health and substance abuse and prescription drugs, Members have additional appeal rights available under Vermont State law (Rule H-2011-02). Members can request an independent external review of an appealable