NON FORMULARY COVERAGE DETERMINATION FOR PLANS WITH A MANAGED FORMULARY

The AultCare Managed Formularies are designed to provide value. Only specific drugs in each therapeutic class are covered. The formulary designs provide adequate options in each therapeutic category and includes most generics and selected brands. Unless a coverage determination is approved, only medications listed on the formulary are covered under your plan.

How to ask for a coverage decision for a non formulary (not covered) medication.

You may ask our plan to make a coverage decision about the drug(s) you need that are not covered on your managed formulary. If your health requires a quick response, you must ask us to make an "urgent or expedited decision." You cannot ask for an urgent or expedited decision if you are asking us to pay you back for a drug you already bought.

What to do:

You or your doctor (or other prescriber) can request a coverage determination by calling, emailing, writing, or faxing our plan at the numbers below.

Telephone: 330-363-6360 or toll free 1-800-344-8858

Email: AultCarePharmacy@aultcare.com

Fax: 330-363-3284

Mail: 2600 Sixth Street S.W. Canton, Ohio 44710 Attn: AultCare Pharmacy Department

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the urgent or expedited deadlines. A standard decision means we will give you an answer within 72 hours. An urgent decision means we will give you an answer within 24 hours. An expedited decision means we will give you an answer within 24 hours.

- To get an expedited decision, you must meet the following requirement:
    - You can get an expedited decision **only** if using the standard deadlines could cause serious harm to your health or hurt your ability to function. (e.g. when an enrollee is suffering from a serious health condition and currently undergoing a current course of treatment using a non formulary drug.)
- If your doctor or other prescriber tells us that your health requires an "expedited decision," we will automatically agree to give you an expedited decision.

- If you ask for an expedited decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you an expedited decision.
    - If we decide that your medical condition does not meet the requirements for an expedited decision, we will verbally communicate with you.

Our plan can approve or deny your request:

If we approve your request we will provide the coverage we have agreed to within the appropriate time frame. If we deny your request, we will send you a written notice that explains why we denied. If your request is denied you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.