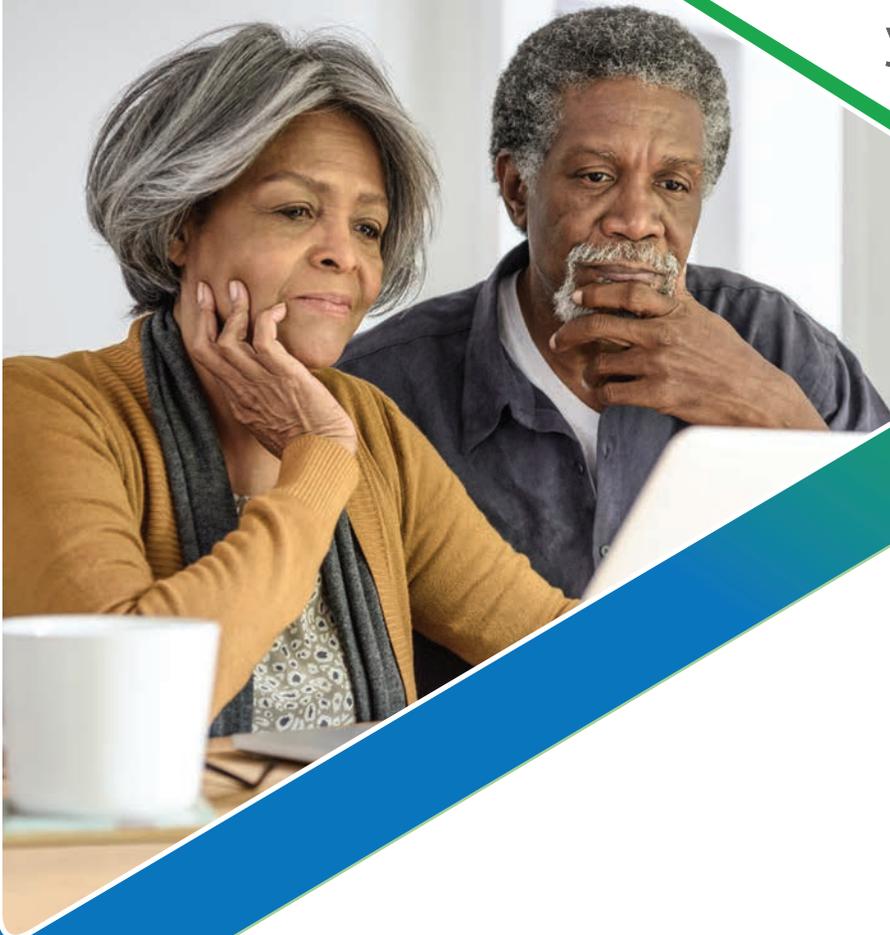


Take Control, Request Access

Your guide to
requesting access to
your diabetes therapy



Diabetes
ACCESS AHEAD



Welcome

We know that accessing your diabetes therapy is important to you. If your health plan decided not to cover your therapy, you may be left with more questions than answers. But don't worry—you're not alone in these challenges. While rejection from health plans is a common reason for not getting a therapy, about 40% to 50% of rejections are overturned.

This all-in-one resource was created to help you request access to your therapy and to understand

- Your options when dealing with your health plan
- The appeals process for private and Medicare Part D insurance
- What you need to submit an appeal
- How your doctor can help you
- Answers to questions about insurance
- Diabetes resources in your community
- Key insurance terms
- Your legal rights to healthcare

Having the right information can help simplify the process—and help you take control of your health. In this guide, you can find additional resources for support.

This guide was sponsored by Sanofi and was created with the help of the following organizations.



Help is within reach

Everyone should have the right to access the treatments they need. This guide can help you when your health plan denies coverage.

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Understand your options

Determining if your health plan covers the therapy you need is important to managing your diabetes. Unfortunately, there are a few cases where your health plan may not cover your therapy:



- Your doctor prescribes a new therapy that isn't covered by your health plan
- Your health plan changed some of the therapies it covers and your therapy is no longer included
- You switched health plans and your therapy is not covered by the new plan

Your pharmacist may tell you that your health plan doesn't cover your medicine. Don't worry, this doesn't always mean you can't get coverage.

Requesting an exception

You may find out that your therapy isn't covered when you're at the pharmacy to pick it up. Let your pharmacist know that you'd like your doctor to request an exception. You or your pharmacist can call your doctor to explain the situation. To request an exception, your doctor will need to fill out forms from your health plan. These forms explain why you need this therapy. Your doctor will also need to prove that there is no alternative for you. If your health plan agrees with your doctor, your therapy will be covered.

What happens if coverage is denied?

If your health plan denies the exception, you may be responsible for the full cost of your therapy. Even if your therapy is included on your health plan, it may still be denied. In this case, your plan doesn't consider the treatment necessary for you. If this happens, you have the right to appeal this decision.

Talking to your health plan

Calling your health plan after receiving a coverage denial is an important step. While you may feel frustrated, talking to someone at your plan can help you get the information you need. You may even be able to resolve the issue without having to submit an appeal.

Plan X Health Plan	New Jersey
Group Number: ABC-XXX-YZA	Payer ID: 0000-ABC
Member ID: 0000-1234-0000	
Member/Patient Name: Joe Doe	<div style="border: 1px solid green; padding: 5px;"> Rx Bin: 000321 Rx Grp: Acme Rx PCN: 6155 </div>
PCP Name: Charles Wellness	
PCP Name: (800) 345-5555	
Effective Date: 01/01/18	
<p>In an emergency go to the nearest hospital or call 911 This card does not guarantee coverage. For coordination of care, call your PCP. To verify benefits or to find a provider, visit the website: www.planX.com</p> <p>For Members: 800-555-1200</p> <p>Non-Emergency Transportation: 877-555-2134 Outpatient Mental Health: 877-770-8800 Vision: 800-555-0987</p> <p>For Providers: www.planX.com 800-555-0987 Medical Claims: PO BOX 00000, Any City, AS 00000-0000</p> <p>Pharmacy Claims For Pharmacists: 800-123-0987</p>	

The phone number for your health plan is on the back of your insurance card.

Here are some questions you might want to ask



1. Can you explain why my coverage was denied?
2. Was there a simple error that my doctor can correct?
3. Can you tell me if a similar treatment will be covered?
4. What is the process to challenge this decision?
5. How long will I have to wait for a decision?
6. Will my therapy be covered while the appeal is being processed?
7. What are my options if my therapy is still not covered?



You have the right to an appeal if your medical exception request is denied.



Review the appeals process

You have the right to file an appeal if your health plan denies coverage. Here's how the process works if you have private insurance or are covered under Medicare Part D. Keep in mind that each state may have a different appeals process. Be sure to check with your plan to confirm the specific process before submitting any appeals.

If you have commercial insurance (example)*

Call your health plan

- You may be able to resolve the issue with a simple phone call
- Note the names of those you speak to and details from the call, such as the date

Submit an INTERNAL 1st level appeal

- This type of appeal is submitted right to your health plan
- You or your doctor can submit the appeal
- Let your doctor know if you choose to submit the appeal yourself

Submit an INTERNAL 2nd level appeal

- If the first appeal is denied, you can submit a second
- This will be reviewed by a medical director who did not review the first one

Request an EXTERNAL review

- If both internal appeals are denied, you can request an external review
- Your plan will give you instructions on how to request this
- A third party who is not affiliated with your health plan, such as a cardiologist or endocrinologist, will review your appeal

Contact your state's insurance commissioner or attorney general

- If your external review is not successful, you can report this to your state's insurance commissioner
- Visit NAIC.org for the name of your state's insurance commissioner
- For more information about your rights, refer to the back cover of this guide
- You can also contact Aired Alliance at 202-559-0380 or visit www.coveragerights.org

If you're covered under Medicare Part D (example)†

You also have the right to an appeal if you're covered under Medicare Part D. The process is a little different than with private insurance. If you disagree with your health plan's decision, you have the right to request up to 5 levels of appeals. You can visit www.medicare.gov/claims-and-appeals for more information about the appeals process for Medicare Part D.

Coverage Redetermination

- This is a second review of your health plan's decision
- You may be able to ask for a faster decision if your doctor feels the issue is urgent

Reconsideration by an Independent Review Entity (IRE)

- If the redetermination is unsuccessful, you can request a review from an Independent Review Entity
- Like an external review, this type of request is handled by a third party that is not affiliated with your plan

Hearing before an Administrative Law Judge (ALJ)

- If you disagree with the IRE's decision, you can request a hearing
- This gives you the chance to present your case to a new, impartial person
- The amount you would owe for your therapy must be \$160 or more

Review by the Medicare Appeals Council (MAC)

- If you disagree with the decision of the ALJ, you can request a MAC review
- There is no minimum dollar amount required for a review by the council

Judicial review by a federal district court

- If you disagree with the MAC's decision, you can request a judicial review
- This is the last level of appeal that you can request to get your therapy covered
- The amount you would owe for your therapy must be \$1,600 or more

*Examples of private (commercial) plans include Aetna, UnitedHealthcare, and Cigna. Your health plan may also use a pharmacy benefit manager (such as Express Scripts) to handle prescription therapies.

†Examples of Medicare Part D plans include SilverScript and WellCare. Many commercial health plans may also offer Medicare Part D coverage.

Prepare your appeal

There are several important documents you'll want to include when you submit your appeal. Use the checklist below to make sure you have everything you need.



- A letter written by your doctor explaining why the treatment is needed
- A letter written by you explaining why the health plan should reconsider its decision (see the template on the next page to help you get started)
- Relevant lab results and any other chart notes from your doctor
- The package insert for your therapy, which can be found on the product's website
- Journal articles or clinical studies showing the effectiveness of the therapy (your doctor can help you find articles or studies or print them out for you)

Before sending the documents to the health plan, make copies of each one for your records. Also, ask for a return receipt from the post office. Keep this with the other paperwork related to the appeal.

Working with your doctor

Your doctor is your best ally throughout the appeals process. Even if you're submitting the appeal yourself, your doctor can still provide support and information. Some tips to keep in mind when talking to your doctor:



- Prepare a list of questions in advance
- Ask your doctor if he or she can call your health plan on your behalf — this call may resolve the issue that led to the denial
- Find out if there's someone at your doctor's office who can help with your appeal
- Keep detailed notes of your conversations to help if questions come up
- Follow up with the office to share updates throughout the process

Writing your appeals letter

While your doctor's office may be able to write a letter for you, it may be more effective to write one yourself. The template and tips on the right will help you get started with your appeals letter.

[Health plan name]
[Health plan address]

[Your name]
[Your date of birth]
[Your address]
[Your health plan ID number]
[Your group/policy numbers]

[Date]

Re: Request for reconsideration of coverage denial for [insert patient's name, insert patient's policy ID number]

Dear Member Services/Member Appeals,

I am writing in reference to the denial that I received on [date] for [therapy name]. The letter stated that [therapy name] was not covered because [reason(s) for denial]. After speaking with my physician, Dr. [doctor's name], I am requesting that you reconsider this decision.

I was diagnosed with [condition] by Dr. [doctor's name] in [year]. This condition negatively affects my day-to-day life in several ways. [Provide examples of how your diabetes impacts your daily life]. To treat my condition, my doctor has prescribed [list therapies you are taking, or have taken in the past]. I have experienced [negative side effects] from taking [current or past therapy].

[Therapy name] has been proven to [describe what the therapy will do to help your condition]. Based on this, and my medical history, I believe that you should approve coverage for [therapy name]. In the enclosed Letter of Medical Necessity, Dr. [doctor's name] has described why [therapy name] is medically necessary for me, based on my condition and medical history.

I have enclosed other documents to support treatment with [therapy name]. Please contact me at [your phone number], or contact Dr. [doctor's name] at [doctor's phone number] if you have questions or need additional information.

I look forward to hearing from you by [deadline for decision listed on the denial letter].

Sincerely,
[Your name]
[Your address]
[Your phone number][Your email address][Your policy ID number]

Enclosures: [List contents of your appeals submission]

1.

2.

3.

4.

1. Use exact terms from the denial letter
2. Describe your condition and how it affects your daily life
3. List the benefits of the therapy
4. Include contact information for you and your doctor



Get answers to your insurance questions

Q: Why would my health plan deny coverage for a therapy?

A: There are a variety of reasons why your health plan would decide not to cover your therapy, such as

- Your doctor's office sent the claim to the wrong health plan
- The therapy is not considered medically necessary
- Your health plan has not yet reviewed this therapy
- Your health plan reviewed the medication and decided not to cover it
- The therapy is still under investigation

Q: Why can't I get my therapy even though it's covered by my health plan?

A: Even if your health plan covers your therapy, it may be restricted for certain people. If there is a step therapy restriction, you'll need to try a different therapy first before you can take the one prescribed by your doctor. If there is a prior authorization restriction, your doctor will need to fill out forms proving why you need this therapy. For more information on step therapy and prior authorization, see page 15 of this guide.

Q: Can coverage be denied for a therapy that I'm already taking?

A: Your health plan may deny coverage when you try to refill your current therapy. This may happen if your health plan decides that it will no longer cover your medication or if you change health plans. You still have the right to file an appeal in this case.

Q: What should I do before calling my health plan?

A: Before you contact your plan, you should

- Carefully read the denial letter and write down any questions you may have
- Reach out to your doctor for more clarity on the prescribed therapy being denied
- Review your specific health plan to determine your options for filing an appeal
- Check with diabetes advocacy groups to see if they offer support with insurance issues (see page 12 of this guide for more information about these groups)

Q: How soon do I need to file an appeal after a coverage denial?

A: For an internal appeal, many plans require you to submit your paperwork within 180 days of receiving the denial letter. For an external review, many plans require you to submit the appeal within 60 days. Refer to your denial letter for the exact deadlines, as it may differ by plan. No matter the deadline, you should put together the appeal request as soon as possible. It may take up to 60 days to get a decision from your health plan after you submit your appeal.

Q: When can I request an expedited appeal?

A: If you or your doctor thinks your appeal is urgent, you may request an expedited verbal appeal. In this case, your health plan would need to make a decision shortly after receiving the request. This can be requested if you're already taking or were prescribed the therapy and your doctor feels that a delay could cause you serious health problems. You cannot request an expedited appeal if you disagree with a denial for a procedure that your doctor already performed or if your doctor does not feel that your situation is urgent.

Q: Can I appeal a coverage denial for a service received outside of my network?

A: You may be able to submit an appeal for service received outside of your network. If you were not able to find a suitable in-network doctor in your area, your health plan may agree to cover the service. Before starting the appeals process, check that there are no in-network doctors in your area who could have provided the service.

Q: What happens if coverage is still denied after an external review?

A: After you've exhausted the appeals process, your last option is to pursue legal action. If you choose to accept the denial, you will be responsible for the full cost of your therapy. On page 13 of this guide, you can find information on resources to help you pay for your therapy. You can also reach out to your doctor to consider other treatment options. Before you're prescribed an alternate treatment, you and your doctor should make sure it's covered by your health plan.

Q: If I want to change health plans, what should I consider?

A: You can change your health plan during the open enrollment period. You may qualify for a special enrollment period outside of the annual open enrollment. This allows you to enroll in a health plan if you've had certain life events, like getting married, having a baby, or losing health coverage.

Before deciding on a new plan, first make sure that this plan covers your therapy. You should also consider

- How much your therapies will cost
- The plan's deductible
- The types of diabetes therapies covered under the plan's formulary
- If the plan restricts any of your diabetes therapies (eg, prior authorization, step therapy)

Health plans are required by law to provide you with a Summary of Benefits, which is a document that explains the different plan options they offer. You can use the information in these summaries to compare plans and see which options work best for you.



Find support

You're not alone in your diabetes treatment. There are many organizations that can answer your questions and advocate for you. Contact any of these organizations or visit their websites to learn more about efforts in your area.

Aimed Alliance

Aimed Alliance works to improve access to therapies and help people understand their healthcare rights.

1-202-559-0380
www.aimedalliance.org
www.coveragerights.org

American Association of Diabetes Educators (AADE)

The AADE is dedicated to improving diabetes care through education, management, and support.

1-800-338-3633
www.diabeteseducator.org

Diabetes Patient Advocacy Coalition (DPAC)

The DPAC is an alliance of people with diabetes, caregivers, patient advocates, health professionals, disease organizations, and companies working to promote and support public policy initiatives to improve the health of people with diabetes.

1-202-629-0400
info@diabetespac.org
www.diabetespac.org

DiabetesSisters

DiabetesSisters provides online and in-person support and education for women living with all kinds of diabetes, including pre-diabetes.

info@diabetessisters.org
www.diabetessisters.org

The diaTribe Foundation

diaTribe is a patient-focused online publication, and is part of The diaTribe Foundation's mission to improve the lives of people with diabetes.

1-415-241-9500
www.diatribefoundation.org

Taking Control of Your Diabetes (TCOYD)

TCOYD holds conferences, health fairs, and retreats in many states.

1-800-998-2693
www.tcoyd.org

Consumer assistance programs

Your state may also offer a consumer assistance program. If so, your health plan should give you the program's contact information in your denial letter. These programs can help with the appeals process and help you understand your rights. To find out if your state offers a program, visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

If your state does not have a consumer assistance program, your state's Department of Insurance may be able to help you through the appeals process.

Offsetting your out-of-pocket costs

Depending on the type of insurance you have, you may qualify for different types of financial support.



If you have private insurance, you may qualify for a copay or savings card program from the drugmaker. These cards can help cover some, or all, of the out-of-pocket costs for your therapy. Visit the drugmaker's website to check if this type of program is available. Your doctor may also have this information on hand in the office.

Before you can use your card, you'll need to activate it. You can do this either online or by calling the number printed on your card. If you receive a physical card, be sure to bring it to the pharmacy when you pick up your therapy. Keep in mind that some programs may not have a physical card. In this case, you may only need the card number to get the savings.



If you're covered under Medicare and meet certain income requirements, you may qualify for Extra Help with your prescription costs. To find out if you qualify for Extra Help, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

Other resources are available to help you cover the cost of your therapy, no matter what type of insurance you have. Search for your therapy through these websites to see if you qualify for any available programs.

The Partnership for Prescription Assistance: (www.pparx.org)

NeedyMeds: (www.needymeds.org)

RxAssist: (www.rxassist.org)

Rx Outreach: (www.rxoutreach.org)

Learn key insurance terms

When working with your health plan, you may come across some terms you might not know. Knowing what these terms mean can help you get the most out of these discussions.

Appeal:

A request for the health plan to reconsider its decision to deny coverage for a medical treatment. There are 3 main types of appeals. The number of appeals you can submit may vary by plan.

First level appeal: Initial request to review whether the health plan incorrectly denied coverage.

Second level appeal: A second request reviewed by a health plan's medical review board not involved with the initial appeal.

External review: A review by a third party that is not affiliated with the health plan if all internal appeals are exhausted.

Benefit:

Treatments covered by your health plan. There are 2 types of benefits:

Medical benefit: Coverage for treatments or procedures typically performed in your doctor's office.

Pharmacy benefit: Coverage for prescription therapies typically taken at home.

Claim:

A request for a health plan to pay for a treatment.

Explanation of Benefits (EOB):

A statement from the health plan explaining the treatment, the amount the plan will pay, and the amount that you owe. An EOB will also explain why coverage was denied.

Formulary:

A list of therapies covered by your health plan.

Grandfathered health plan:

A health policy that was purchased on or before March 23, 2010. This is when the Affordable Care Act went into effect. These plans may not include some of the rights provided under the act, such as free preventative care and coverage for pre-existing conditions.

Grievance:

A formal complaint about issues not involving coverage or payment, such as the level of service from your health plan.

Medically necessary:

Treatments needed to prevent, diagnose, or treat a condition or its symptoms. This also means the treatment meets accepted medical standards.

Network:

The doctors and facilities that your health plan has chosen to provide care to its members.

Pharmacy Benefit Manager (PBM):

A company that handles prescription drug coverage for health plans, medical providers, or employers. A PBM can set up the formulary, negotiate with drugmakers, and process claims for coverage.

Prior authorization (PA):

A tool used by health plans or PBMs to make sure a therapy is only used when needed. If a PA is required, a doctor must submit paperwork proving that the drug is medically necessary.

Quantity limit:

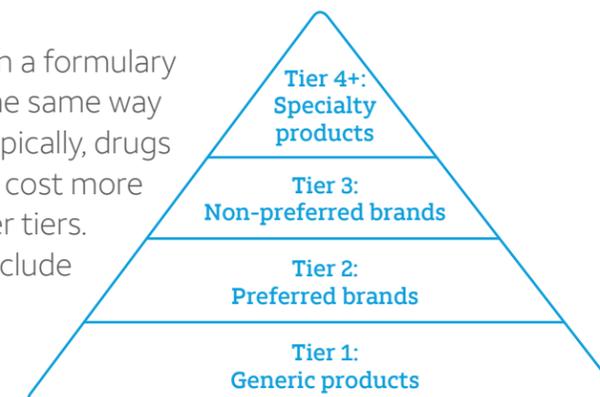
A set number of refills of a therapy covered by the health plan during a given period of time.

Step therapy:

A coverage rule where the health plan requires you to first try a lower-cost therapy before it will cover the original drug prescribed by your doctor.

Tier:

A group of drugs on a formulary that are covered the same way by a health plan. Typically, drugs on a higher tier will cost more than drugs on lower tiers. A formulary may include the following tiers:



Know your rights

You have certain rights and protections. Here are some rights to keep in mind:

- 1.** Your health plan cannot charge you more or drop your coverage because of a pre-existing condition
- 2.** You can choose any primary care doctor in your health plan's network
- 3.** Your doctors must give you the information you need to make decisions about your treatment
- 4.** You have the right to get a copy of your medical records and to keep this information private
- 5.** You have the right to an appeal if your health plan denies coverage for your medication
- 6.** Your health plan cannot drop you or raise your rates because you appealed a decision
- 7.** An employer cannot fire you or not hire you because of your diabetes

For more information about your rights, contact Aimed Alliance or visit [CoverageRights.org](https://www.coveragerights.org).



Check with your health plan to find out more about your rights as a patient.