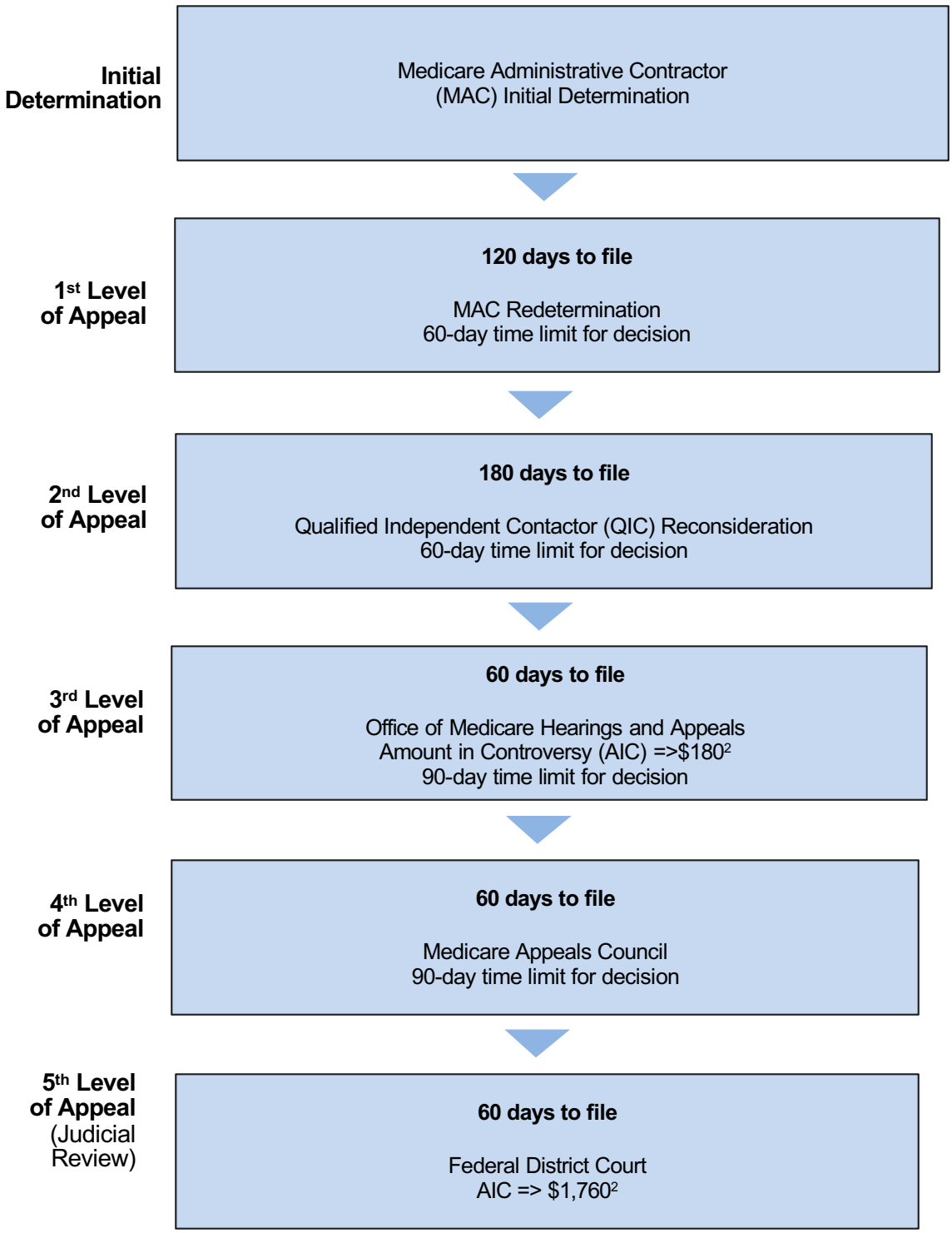
Medicare Part A and Part B (Fee-for-Service) Appeals Process

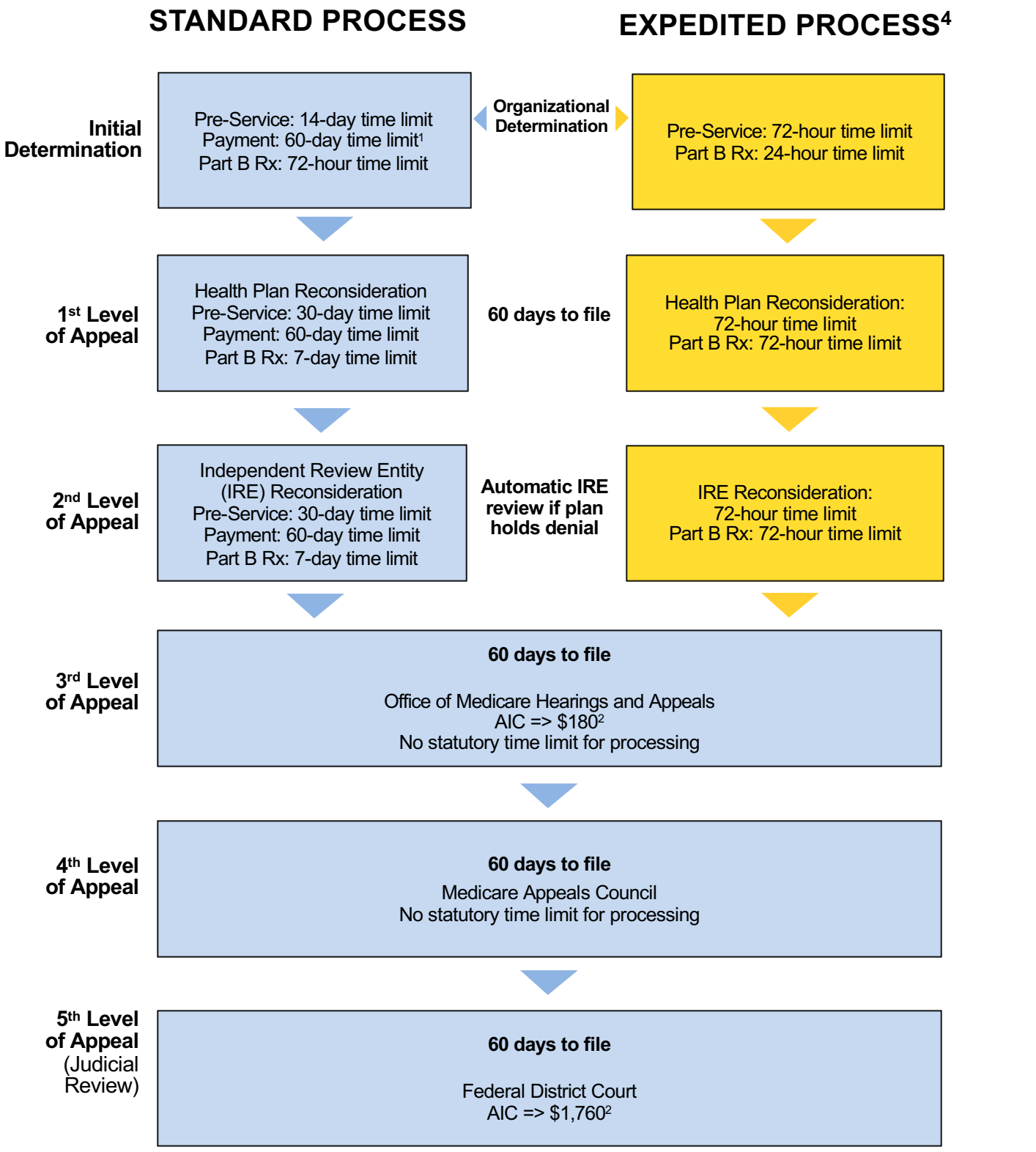
STANDARD PROCESS



[2] The AIC requirement for all appeals at the Office of Medicare Hearings and Appeals (OMHA) and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2021 AIC amounts.

NOTE: The time to file starts when the previous decision or determination is received.

Medicare Part C (Medicare Advantage) Appeals Process

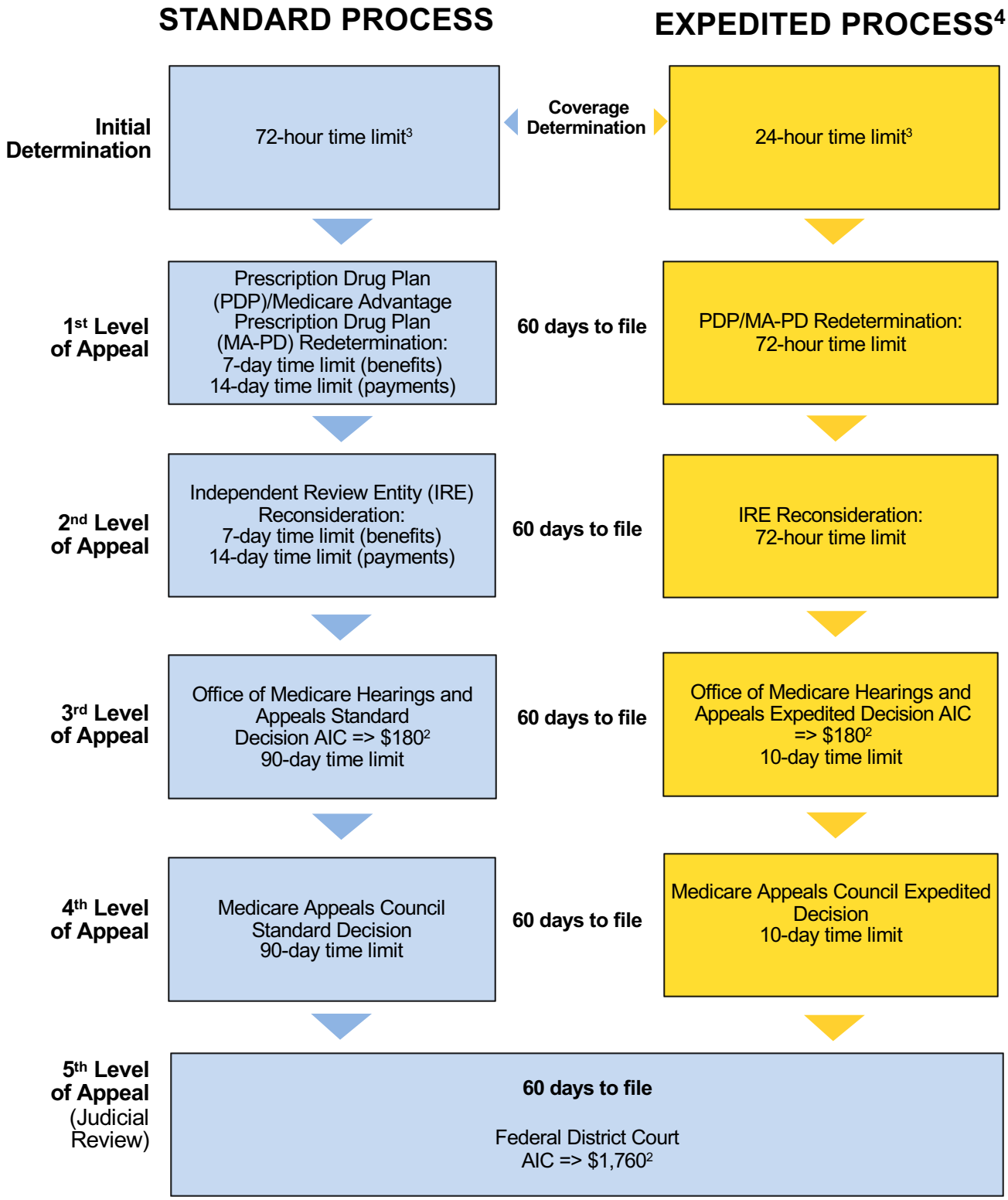


[1] Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.

[2] The AIC requirement for all appeals at the Office of Medicare Hearings and Appeals (OMHA) and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2021 AIC amounts.

[4] Plans may, but are not required to, expedite payment requests.

Medicare Part D (Drug) Appeals Process



[2] The AIC requirement for all appeals at the Office of Medicare Hearings and Appeals (OMHA) and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2021 AIC amounts.

[3] A request for a coverage determination includes a request for a tiering exception or a formulary exception. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.

[4] Plans may, but are not required to, expedite payment requests.