Our Grievance, Coverage Determination (including exceptions) and Appeals Process

This is only a brief summary about our Grievance, Appeals, and Coverage Determination (including exceptions) Process. Additional information can be found in Chapter 9 of the Evidence of Coverage booklet accessible on this website. Please refer to your Evidence of Coverage book for more details.

Grievances

What Is a Grievance?

Any complaint or dispute, other than one that involves a coverage determination or an LIS or LEP determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of Alignment Healthplan, regardless of whether remedial action is requested. A grievance may also include a complaint that we refused to expedite a coverage determination or redetermination. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

When Can a Grievance Be Filed?

You may file a grievance within sixty (60) calendar days of the event or incident date that precipitates the grievance. There is no filing limit for complaints concerning quality of care filed with the QIO (Quality Improvement Organization).

Expedited Grievance

You have the right to request a fast review or expedited grievance if you disagree with Alignment Healthplan's decision to invoke an extension on your request for an organization determination or reconsideration, or Alignment Healthplan's decision to process your expedited request as a standard request. In such cases, Alignment Healthplan will resolve your grievance within twenty-four (24) hours of receipt and notify you in writing.

Where Can a Grievance Be Filed?

A grievance may be filed in writing directly to us or by contacting our Member Services Department at 1-866-634-2247, TTY: 711, 8:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

You may also contact our Member Services Department and request the mailing address or facsimile number for Appeals and Grievances.

Coverage Determinations

What Is a Coverage Determination?

A coverage determination is a decision made by Alignment Healthplan about your prescription drug benefits. This includes whether a particular drug is covered, whether you have met all the requirements for getting a requested drug, how much you are required to pay for a drug, and whether to make an exception to a plan rule when you request it.

What Is an Exception?

An exception is a type of coverage decision. For example, if a drug is not covered on our plan, you can ask us to make an "exception." Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision. When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved, for us to consider your request.

When Can a Coverage Determination/Exception Be Requested?

A coverage determination may be requested for any of the following:

1. Covering a Part D drug for you that is not on our plan's List of Covered Drugs (Formulary).

    a. You may ask our plan for an exception if you or your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes you need a drug that isn't on your drug plan's list of covered drugs.

    b. You may ask for an exception if your network pharmacy can't fill a prescription as written.

2. Removing a restriction on the plan's coverage for a covered drug.

    a. You may ask for an exception if you or your prescriber believe that a coverage rule (such as a prior authorization) should be waived

3. Changing coverage of a drug to a lower cost-sharing tier. (Tier Exception)

    a. You may ask for an exception if you think you should pay less for a higher tier drug because you or your prescriber believe you can't take any of the lower tier drugs for the same condition.

4. Request for payment.

    a. You may ask us to pay for a prescription that you already bought.

Where can a Coverage Determination/Exception be Filed?

A Coverage Determination/ Exception may be filed in writing to:

Alignment Health Plan
Attn: Member Services Department
1100 W. Town and Country Road
Orange, CA 92868

You may also call Alignment Health Plan at 1-866-634-2247, TTY: 711, 8:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. In addition, you may file an Exception through our website at www.alignmenthealthplan.com.

Member Appeals & Redeterminations

What Is an Appeal?

An appeal is a type of complaint you make when you want us to review a decision that was made regarding coverage of a medical service, the amount we paid for a medical service, will pay for a medical service or the amount you must pay for a medical service.

What Is a Redetermination?
The first level of the appeal process, which involves a Part D drug and Alignment Healthplan re evaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

When Can an Appeal Be Filed?

You may file an appeal within sixty (60) calendar days of the date of the notice of the initial organization determination (or coverage determination, for Part D).

Note: The sixty (60) day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60) day timeframe.

Where Can an Appeal Be Filed?

An Appeal (or Part D Redetermination) may be filed in writing directly to us or by contacting our Member Services Department at1-866-634-2247, TTY: 711 66:00 a.m. to 8:00 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

You may also contact our Member Services Department and request the mailing address or facsimile number for Appeals (including Redeterminations). In addition, you may file a Part D Redetermination through our website at www.alignmenthealthplan.com.

Fast Decisions/Expedited Appeals

You have the right to request and receive expedited decisions affecting your medical treatment in "Time-Sensitive" situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the timeframe of the standard decision-making process could seriously jeopardize:

- your life or health, or
- your ability to regain maximum function.

If Alignment Healthplan, your Primary Care Physician, or your prescriber (for Part D) decides, based on medical criteria that your situation is Time-Sensitive or if any physician calls or writes in support of your request for an expedited review, Alignment Healthplan will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request.

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