Liberty Health Advantage (HMO)

Summary of Grievance and Appeal Process for Medicare Advantage
Part D Drug Benefits

Member Grievances/Complaints
A grievance is a complaint for certain types of problems with Liberty Health Advantage HMO (LHA) or one of our network pharmacies that does not relate to coverage for a prescription drug. Grievances do not relate to **coverage determinations** which are decisions regarding payment for or approval of a prescription drug. You would file a grievance if you have a problem such as issues with the waiting time when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone, getting information you may need, or the cleanliness or condition of a network pharmacy.
You or your representative may file a grievance on your behalf. If your representative files your grievance, both you as the member and your authorized representative must sign and date a statement giving the representative permission to act on your behalf as the member.

Filing a Grievance/Making a Complaint
A grievance may be filed either orally by contacting our Member Services department or in writing to:

Liberty Health Advantage HMO
Attention: Grievances and Appeals
1 Huntington Quadrangle, Suite 3N01
Melville, New York 11747
Toll Free Phone: 1-866-542-4269
TTY/TDD: 1-800-662-1220
Fax: 1-866-542-6359

You must file a grievance within sixty (60) calendar days after the event or incident that precipitates the grievance.
Grievances will be resolved as expeditiously as the case requires based on your health status, but no later than thirty (30) calendar days from the date after LHA receives the oral or written grievance. LHA may extend the thirty (30) day timeframe by up to fourteen (14) days, if you request such an extension or LHA justifies a need for additional information and documents how the delay is in your best interests. When LHA extends the deadline, we will notify you immediately in writing of the reasons for the delay.

If you file a grievance because we denied your request for a "fast" response to a coverage determination or appeal, we will automatically give you a "fast" grievance, meaning we will give you an answer within twenty-four (24) hours.

Coverage Determinations and Exceptions
A coverage determination is a decision LHA makes about your prescription drug benefits and coverage or about the amount we will pay for your prescription drugs.
You or your representative may request a coverage determination on your behalf. If your representative files your coverage determination, both you as the member and your authorized representative must sign and date a statement giving the representative permission to act on your behalf as the member. Your doctor or other prescriber may file a request for a coverage determination, upon notification to you, without being appointed as your representative

To request a coverage determination contact:

Medicare Part D Coverage Determinations / Exception
P.O. Box 407
Boys Town, NE 68010
Toll Free Phone: 1-800-546-5677
TTY/TDD: 1-866-706-4757
FAX: 1.800.458.1646

The decision about whether LHA will cover a Part D prescription can be a "standard" coverage determination that is made within seventy-two (72) hours, or can be a "fast" coverage determination that is made within twenty-four (24) hours.

If your doctor or other prescriber requests or supports your request for a fast decision and shows that waiting for a standard decision could seriously harm your health or ability to function, we will automatically give you a fast decision.

If you ask for a fast coverage determination without support from your doctor or other prescriber, we will decide if your health requires a fast decision. If LHA decides that your medical condition does not meet the fast decision requirements, you will be sent a letter telling you that we will supply a fast decision if you get your doctor's or other prescriber's support. The letter will also inform you on how to file a grievance if you disagree with our decision. If we deny your request for a fast decision, we will provide a decision within the standard seventy-two (72) hour time frame.
For a standard coverage determination, we will give you a decision within seventy-two (72) hours of receiving your request or sooner if your health requires.

If you request an **exception –** including a formulary exception, tiering exception or an exception from utilization management rules, such dosage, quantity limits, or step therapy requirement – we must decide whether the exception is approved. Your

doctor's or other prescriber's supporting statement needs to explain why the drug you are requesting is medically necessary.

If LHA does not give you a decision within seventy-two (72) hours of receiving your request for an exception, we are required to send your request to an independent review organization.

If you qualify or a fast coverage determination about a Part D drug you have not yet received, we will give you a decision in twenty-four (24) hours or sooner if your health requires.

If your request is for an exception, LHA has to decide within twenty-four hours of receiving the supporting statement from your doctor or other prescriber.
If LHA decides you are eligible for a fast review and you do not receive an answer from LHA within twenty-four (24) hours after receiving your request, LHA is required to send your request to an independent review organization.

If LHA decides completely in your favor:

For a standard decision about a Part D drug, including request for payment for a Part D drug that you have already received: LHA must authorize the benefit as quickly as your health requires bur no later than seventy-two (72) hours after LHA received the request.

For an exception: LHA must authorize or provide the benefit no later than seventy-two (72) hours after it receives your doctor's supporting statement. If you are requesting reimbursement for a drug that you have already paid for and received, LHA must send payment to you no later than thirty (30) calendar days after we receive the request.

For a fast decision about a Part D drug: LHA must authorize or provide the benefit no later than twenty-four (24) hours after receiving your request. If your request is for an exception, LHA must authorize or provide the benefit no later than twenty-four (24) hours after receiving the supporting statement from your doctor or other prescriber.

If LHA denies your request, a written decision explaining the reason your request was denied and your right to an appeal.

Filing an Appeal

An appeal may be filed in writing to:

Medicare Part D Appeals
P.O. Box 407
Boys Town, NE 68010
Toll Free Phone: 1-800-546-5677
TTY/TDD: 1-866-706-4757

FAX: 1.800.458.1646

You may file an appeal within sixty (60) calendar days of the date of notice of the coverage determination.
You or your representative may file an appeal on your behalf. If your representative files the appeal, both you as the member and your authorized representative must sign and date a statement giving the representative permission to act on your behalf as the member. Your doctor or other prescriber may file a standard appeal, upon notification to you, without being appointed as your representative

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

Standard Appeals (Re-determinations)
Liberty Health Advantage will consider your appeal and notify you in writing of our decision using the following time frames:

If the request is granted in whole or part, LHA will make a determination and provide notice within seven (7) calendar days of the receipt of your appeal.

If the request is for payment for a drug you have already bought, LHA is required to send payment within thirty (30) calendar days after we receive your appeal request.

If the request is denied, LHA will send written notice and instructions on how to file an appeal with the independent review organization.

Fast Appeal/Expedited Appeals (Re-determinations)
A member or their prescribing physician/other prescriber must make a verbal or written request for coverage. LHA will promptly decide whether to expedite the request.

NOTE: Fast appeals are not offered for payment requests.
Liberty Health Advantage will consider your fast appeal and notify you in writing of our decision using the following time frames:

If the request is granted in whole or part, LHA will make a determination and provide notice within seventy-two (72) hours of the receipt of your appeal. If additional medical information is needed the member and prescribing physician will be notified immediately.

If the request for a fast appeal is denied in whole or part, LHA will send you a written statement explaining why we denied your appeal and how to appeal our decision.

For more information on the Appeals process, Refer to Chapter 9 of your EOC for more information of your Evidence of Coverage or call our Member Services department at 1-866-542-4269 (TTY/TDD: 1-800-662-1220), 8AM to 8PM.