MURRAY STATE UNIVERSITY PRESCRIPTION PLAN COMPLAINT AND GRIEVANCE PROCESS

There is a formal complaint and appeal process for handling Member concerns. A complaint is an oral or written expression of dissatisfaction. An appeal is a request to change a previous decision made by Express-Scripts for the Prescription Benefit. If a Covered Person has a problem or complaint regarding any aspect of the administration of benefits by Murray State University Prescription Plan, the Member may contact the Murray State University HR Benefits Office or Express Scripts Member Services to discuss the matter. If the matter cannot be resolved within a UHDVRQDEOH WLPH WR WKH 0HPEHU¶V VDWLVIDFWLRQ WKH 0HPEH

Step 1 - Coverage review description

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is EDVHG RQ WKH 3ODQ¶V EHQHILW GHVLJQ

How to request an initial coverage review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at www.express- scripts.com/PA.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, is obtained by calling the Customer Service phone number on the back of your prescription card.

Step 2 - How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient

- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Wh[redacted]uest an External Review

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