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 reasonable time to the Member's satisfaction, the Member may submit a written appeal. The Murray State University Prescription plan provides a four-step appeal process to resolve Member concerns. The administrative remedies established by this appeal process must be satisfied before legal remedies are sought.

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:

<u>Clinical coverage review request</u>: 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.

<u>Administrative coverage review request</u>: A request for coverage of a medication that is based on the Plan's benefit design.

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.
Complete the form and mail or fax it to Express Scripts Attn: Benefit Coverage Review Department PO Box 66587 St Louis, MO 63166-6587. Fax 877 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the
patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be
requested by the provider by phone at 1 800-753-2851.

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
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested byphone or fax:

Clinical appeal requests: phone 1 800-753-2851 fax 1 877- 852-4070

Administrative appeal requests: phone 1 800-946-3979 fax 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Step 3 - How to request a level 2 appeal after a level 1 appeal has been denied

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination

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

<u>Clinical appeal requests</u>: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070

<u>Administrative appeal requests</u>: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St Louis, MO 63166-6587 Fax 1 877-328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

<u>Clinical appeal requests</u>: phone 1 800-753-2851 fax 1 877- 852-4070

<u>Administrative appeal requests</u>: phone 1 800-946-3979 fax 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Step 4- External Grievance Process

(A) If a Participant has exhausted the Plan's internal appeals process and the Participant is not satisfied or failed to render a decision within the specific timeframe, a Participant may be eligible for an External Review by an Independent Review Entity under the following conditions:
   (1) The Plan made an adverse determination, as defined in KRS 304.17A-600 (1) (a); Definitions for KRS 304.17A-600 to 304.17A-633:
      (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:
         i. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
         ii. Benefit coverage is therefore denied, reduced, or terminated.
      (b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;
   (2) The Participant was enrolled on the date of the service, or, if prospective denial, was enrolled and eligible to receive covered benefits on the date the service was requested; and
   (3) The entire cost of treatment or service will cost the Participant at least $100 if not covered by the Plan.

(B) A Participant, an authorized person or a Provider with the Participant's consent may request an External Review. The request for review must be received within 4 months of the he final Internal Adverse benefit determination. The confidentiality of all records used in the review shall be maintained throughout the process.

When and How to request an External Review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational.
Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to: MCMC llc, Attn: Express Scripts Appeal Program, 300 Crown Colony Drive. Suite 203, Quincy, MA 02169-0929. Phone: 1 617- 375- 7700 ext. 28253 Fax: 1 617- 375- 7683 and the request must be received within 4 months of the date of the final Internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

How an External Review is processed

Standard External Review: MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.