BMO

Prescription Drug Coverage

Plan Details

EVERNORTH℠
HEALTH SERVICES
Express Scripts® Pharmacy Benefit Services

Quick Facts

Vendor	Express Scripts (Evernorth Health Services)

Overview

When you enroll in a BMO medical plan administered by Blue Cross Blue Shield of Illinois (BCBSIL), you automatically receive prescription drug coverage through Express Scripts, our pharmacy benefits manager. Express Scripts helps manage your prescriptions and your health. Here are a few highlights you can expect:

- **Easy**. Register online or download the Express Scripts mobile app to always have your info with you. Check coverage, compare prices, and see if generic medications are available.
- **Accessible**. Connect with pharmacists in the app, or online and by phone 24/7.
- **Personalized**. Select your communication preferences so you can control how you receive information.
- **Convenient**. Order refills, track shipments, compare prices and access your plan information online.

	Visit www.express-scripts.com First time visitors must register using their member ID or Social Security Number. You can manage your medication online when your coverage takes effect. Before then, you can set up your online account, including your preferred shipping address, preferences, and payment method(s) for home delivery orders. Have a question about Account management & preferences, prescription orders, prices & paying for medication past orders & records, getting medicine: nearby or delivered, prescription rules & coverage, common terms, or taking medicine log in and go to the **Help** menu and select **FAQs & Contact Us** for support!
	Visit your favorite app store to download the Express Scripts mobile app
	Text JOIN to 69717 for a link to Express Scripts registration page Automated text message will be sent to you. Message and data rates apply. Not a condition of purchase.

Prescription Drug Coverage: HDHP vs. PPO

Prescription drug benefits are subject to the annual deductible and out-of-pocket maximum in both HDHP and PPO medical plans, but how you pay for medications can differ. Understanding these variables can help you make informed decisions about your prescription drug spending and maximize your benefits.

There are also certain categories of prescriptions that are considered preventive and therefore not subject to the deductible and either covered at 100% by the Plan or immediately covered at applicable copayment or coinsurance. Your out-of-pocket cost for prescriptions will vary based on your health plan and:

- Where you fill your prescription (retail pharmacy or home delivery)
- What type of drug it is (generic, preferred brand-name, or non-preferred brand-name).

Prescription Category	Examples	Plan Coverage
Affordable Care Act (ACA) Preventive Drug List	Aspirin products, fluoride products, folic acid products, contraceptive methods, smoking cessation products, most vaccines, bowel preps and primary prevention of breast cancer	You pay $0*
	**Not all prescriptions for the listed medications are covered at 100% and are subject to change. Specific criteria, exclusions, and other rules or limitations may apply to all categories (i.e., quantity limit, age, gender).*	
Expanded Preventive Drug List	Maintenance medications to treat conditions such as high blood pressure, high cholesterol, diabetes, asthma and more	Deductible does not apply; you pay applicable copay or coinsurance based on the Plan's cost share structure
Non-Preventive Prescription Drugs	All other covered prescription Medications	After the deductible, you pay applicable copay or coinsurance based on the Plan's cost share structure

	HDHP	PPO
MEDICAL		
Annual Deductible (individual/family)	$1,750/$3,500 (includes *medical and prescription drugs*)	$750/$1,500 (includes *medical only)*
Deductible Type*	Aggregate	Embedded
Annual Out-of-Pocket Maximum (individual/family)	$3,425/$6,850 (includes deductible, copays and coinsurance for *medical and prescription drugs*)	$3,000/$6,000 (includes deductible, copays and coinsurance for *medical and prescription drugs*)
PRESCRIPTION DRUGS		
Annual Deductible (individual/family)	Combined with medical	$250/$500 (includes *prescription drugs only*)
Annual Out-of-Pocket Maximum	Combined with medical	
Generic	Retail: $10 copay | Mail order: $25 copay	
Formulary	30% coinsurance | Retail: $25 minimum; $100 maximum | Mail order: $62.50 minimum; $250 maximum	
Non-Formulary	40% coinsurance | Retail: $50 minimum; no maximum | Mail order: $125 minimum; no maximum	

***How the deductibles work**

The HDHP plan has an "aggregate deductible," which means: As a family, you have one family deductible and out-of-pocket maximum that applies to the entire family. If combined expenses for the family meet the family deductible, the deductible is met for the entire family, and the plan begins to pay coinsurance for the whole family. The plan works similarly for the out-of-pocket maximum.

The PPO plan has an "embedded deductible," which means: Each member of your family has an individual deductible and individual out-of-pocket maximum. If any one person in the family meets the individual deductible amount, the plan starts paying coinsurance for that person. If expenses for two or more family members reach the family deductible amount, the whole family has met the deductible, and the plan begins to pay coinsurance for the whole family. The plan works similarly for the out-of-pocket maximum.

What's Covered

Benefits are provided only if the drugs are prescribed by a physician, deemed medically necessary and considered eligible under the plan. Some covered medications may be excluded from coverage or be subject to Express Scripts' clinical programs, including but not limited to prior authorization, step therapy, quantity limits and refill too soon.

The Plan includes a list of preferred drugs (both generic and brand name) that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary.

Formularies can help you save money by alerting you to more affordable and clinically effective medications. Medications chosen for the formulary have gone through an extensive review process, guided by an independent panel of clinical experts that review quality and efficacy (they're known to work well, with minimal side effects), safety and cost-effectiveness. In addition, the Plan's Formulary is updated periodically and subject to change:

- a drug may be moved to a higher or lower cost-sharing Formulary tier;
- additional drugs may be excluded from the Formulary;
- a restriction may be added on coverage for a Formulary-covered drug (e.g. Prior Authorization);
- a Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

To get the most up-to-date drug information go online to www.express-scripts.com/bmofinancialgroup or call Express Scripts Member Services at 1 - 877-795-2926.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as step-therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

Drugs that are excluded from the formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is:

- medically necessary and essential to the Covered Person's health and safety and/or,

- all Formulary drugs comparable to the excluded drug have been tried by the Covered Person.

If approved through that process, the applicable Formulary copayment or coinsurance would apply for the approved drug based on the Plan's cost share structure. Absent such approval, individuals selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the Covered Person's Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

Important information about your prescription coverage

Specialty Drug Program through Accredo

Specialty medications are drugs that are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. For these types of prescriptions, you are required to fill your prescriptions through the Express Scripts dedicated specialty pharmacy, Accredo Health Group, Inc. You may call Member Services at 1-877-795-2926 for information on how to order your specialty medications or to find out more information about Accredo.

Dispense As Written (DAW)

If you, or your doctor, request a brand-name medication when a generic equivalent is available, you will pay the generic copayment, plus the difference in cost between the brand and the generic. If you cannot take a generic equivalent due to medical necessity, your doctor may request a review and provide supporting documentation on why the brand is medically necessary. If approved by Express Scripts, you will pay the brand copayment.

Exclusive Smart90

Exclusive Smart90 requires you to fill 3–month supplies of long-term prescriptions at a Smart90 retailer (Walgreens or CVS) or through Express Scripts home delivery. Members can get two retail 30-day grace fills for maintenance medications before you must make the switch to a 90-day supply at a Smart90 network pharmacy.

Manufacturer Copay Assistance

Manufacturer copay assistance funds will NOT accumulate towards the deductible or max out-of-pocket amounts.

Evernorth EnGuide Pharmacy

Evernorth EnGuide Pharmacy is dedicated solely to dispensing, packaging, and shipping GLP-1 medications. Given the complexity of these medications, Evernorth EnGuide Pharmacy benefits from a staff of pharmacists specially trained in GLP-1s, giving a more focused level of care to patients and helping them get on the right dose long-term, while advising on any potential side effects.

For home delivery, you may previously have received your GLP-1 medications from Express Scripts® Pharmacy, our home delivery pharmacy, but as of June 15, 2025, you'll be receiving your GLP-1 medications through Evernorth EnGuide Pharmacy/CHD. You may also choose to fill at other in-network pharmacies.

Drug Specific Cap

Infertility medications are covered up to a lifetime pharmacy benefit maximum of $40,000. Once this limit is reached, no additional infertility medication expenses will be reimbursed under the plan.

Over-the-counter (OTC) NARCAN® Nasal Spray (naloxone)

Naloxone is a life-saving medication that can reverse an overdose from opioids, including heroin, fentanyl and prescription opioid medications. NARCAN is not effective for overdoses of non-opioids, such as methamphetamine. Naloxone is safe and will not harm someone if you give it to them when they are not overdosing on an opioid.

Why is NARCAN important?

NARCAN is used in emergency situations to reverse the effects of opioids and allow a person to breathe properly. Anyone can carry naloxone to help respond to an overdose. Individuals who are concerned about the risk of an opioid overdose, including people who use prescription or illicit opioids, their family members, friends and caregivers, and concerned members of the public, should consider having naloxone on hand. This allows them to administer naloxone if they witness someone experiencing an overdose.

Additional help

- To learn how to administer NARCAN, visit: https://www.ama-assn.org/delivering-care/nation-s-overdose-epidemic/how-administer-naloxone

- **Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline** 800.662.4357

Pharmacy Program Descriptions

Formulary Overview: Express Scripts formulary options help decrease prescription drug expenses. To ensure the clinical appropriateness of their formularies, Express Scripts physicians and pharmacists carefully evaluate pharmaceuticals and prepare recommendations for the National Pharmacy & Therapeutics (P&T) Committee, which reviews and approves Express Scripts formularies.

Drug Quantity Management (DQM) makes sure that members are getting the right amount of medication and that it is prescribed in the most efficient way. For example, the doctor may say, “take two 20mg pills each morning.” If that medication is also available in 40mg pills, Express Scripts will contact the doctor about prescribing one 40mg pill a day instead of two 20mg pills. In addition, if the doctor writes the original prescription for 30 pills (a 15-day supply), the new prescription for 30 pills will last a full month — and the members will have just one copayment, not two.

DQM also makes sure that a member’s prescriptions do not exceed the amount of medication that the Plan covers. If the prescription is for too large a quantity, the pharmacist can fill the prescription for the amount that the Plan covers or contact the doctor to discuss other options, such as increasing the strength or getting a prior authorization for the quantity originally prescribed.

Prior Authorization monitors both cost and safety. If a pharmacist tells a member that a prescription requires prior authorization, Express Scripts will need to communicate with the doctor to be sure that the medicine is right and will verify that the Plan covers the drug. This is like when a healthcare plan authorizes a medical procedure in advance.

When a prescription requires prior authorization, the doctor can call Express Scripts or prescribe a different medicine that is covered by the Plan. Only doctors can give Express Scripts the information needed to determine if the drug may be covered. Express Scripts answers its prior authorization phone lines 24/7, and a determination can be made right away. If the medicine is covered, the member will pay the normal copay. If the medication is not covered but the member wants to take it, the member will pay the full price of the medicine.

Step Therapy is a program for people who take prescription medicine regularly to treat long-term conditions, such as arthritis, asthma or high blood pressure. It lets members get the treatment they need affordably.

- First-line medicines are the first step. First-line medicines are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.

- Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines. Second-line drugs are the most expensive options.

The first time a member tries to fill a prescription that is not for a first-line medicine, the pharmacist should explain that step therapy asks the member to try a first-line medicine before a second-line drug. Only the doctor can change the current prescription to a first-line medicine covered by the Plan.

To get a first-line medicine that the Plan covers, a member should ask the pharmacist to call the doctor and ask for a new prescription. If it is easier, the member can also call the doctor to ask for a new prescription. Also, the pharmacist should explain to the member that there's an option to choose a second-line alternative to the first-line medicine. However, because the Plan will not cover second-line drugs until after the member and the doctor have considered a first-line medicine to treat the condition, the member will pay full price for that second-line drug.

For information on Formulary medications, Drug Quantity Management, Prior Authorization or Step Therapy programs contact Express Scripts at 1-877-795-2926. To inquire about specific medications, search medications directly by logging into your account at www.express-scripts.com, or if you are not yet a member, visit the pre-member site at www.express-scripts.com/bmofinancialgroup.

Retail Pharmacy Network

Express Scripts has many participating retail pharmacies across the country where you can purchase smaller quantities of prescriptions to be used for 30 days or less. For example, if your doctor prescribes short-term antibiotics, or you need to quickly get your initial supply of a maintenance drug, just go to a participating retail network pharmacy and present your Express Scripts prescription ID card or digital ID card and pay the applicable copayment or coinsurance.

For a list of participating network pharmacies, visit www.express-scripts.com, or call Member Services at 1-877-795-2926.

If you do not present your prescription drug ID card at the time of your purchase at the retail pharmacy, or if you purchase your prescription from a non-participating pharmacy, you will have to submit the claim yourself to Express Scripts. The amount that you will be reimbursed for using a non-participating pharmacy will be based upon the cost of the drug if you had used a participating network pharmacy. You will be responsible for the amount above the discounted in-network pharmacy rate plus the required copayment/coinsurance. The reimbursement claim is generally responded to within 10 business days.

Log into your account at www.express-scripts.com. Once logged in, on the Benefits tab, simply click on Forms, and then click on the link to start a claim to request reimbursement. You can download and print the Prescription Drug Reimbursement Form and mail it to the address found on the form, or you can also request a blank claim for to be mailed to you. If you are a first-time visitor, take a moment to register. Please remember to have your member ID number and recent prescription number available. If you do not have a recent prescription number, you may still register; just remember to add a prescription number later so that you can fully manage your prescription benefit online.

Home Delivery

Home delivery, also referred to as mail order, is designed for longer-term medication (any medicine you must take for three or more months to control symptoms or to prevent complications from a condition) of up to 90 days. Examples of conditions that might require long-term medicine include high blood pressure, high cholesterol, diabetes, arthritis, heart conditions, and long-term pain. When you need longer-term prescriptions, using home delivery saves you both time and money. Benefits of delivery from Express Scripts includes:

- Up to a 3-month supply of your long-term medicine with each refill
- Medicine shipped to your door
- Online order tracking
- Easy online payments through the extended payment program let you spread out the cost over 3 months
- Access to an Express Scripts pharmacist any time of the day or night

Extended payment program (EPP)
This lets you pay for your delivery prescriptions in three monthly payments (installments), instead of paying the full amount all at once. Each monthly payment is automatically processed using your preferred payment method. **Example**: You order a prescription that costs $90, and your preferred payment method is a credit card. Under the EPP, you would make 3 monthly payments as follows:

- First payment: As soon as your prescription ships, we'll charge your card $30.
- Second payment: 30 days after your prescription ships, we'll charge your card another $30.
- Third payment: 60 days after your prescription ships, we'll charge your card the final payment of $30. EPP does not cover expedited shipping costs. If you select expedited shipping for your order, the total shipping cost will be billed with your first payment.

Medical necessity appeals: Express Scripts performs appeal services internally or facilitates the performance of appeal services through a contracted, independent, third-

party utilization management company. Appeal cases are handled by reviewing available information as well as clinical guidelines and current clinical literature to determine if drug coverage is permitted under the plan's pharmacy benefit coverage rules. The review considers plan rules based on Food and Drug Administration (FDA)-approved prescribing and safety information, as well as relevant clinical guidelines.

WHAT'S NOT COVERED UNDER PRESCRIPTION DRUGS

The Prescription Drug Program does not cover:

- acts of war: injury or illness caused or contributed to international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared;
- allergy serums;
- any charge for the administration of prescription products;
- all illegal medications or supplies, even if prescribed by a duly licensed medical professional;
- any medication, prescription or non-prescription which is taken or administered at the place where it is dispensed;
- any medication which is meant to be taken by or administered in whole or in part while the covered person is treated at a hospital, physician's office or extended care facility, but is instead self-administered or administered elsewhere, unless expressly designated by the pharmacy benefits administrator;
- charges that are in access of the contracted amount;
- claims received later than 12 months from the date of service;
- compound prescriptions unless approved by this plan;
- compounded prescriptions delivered through home delivery, except for specialty prescriptions through a specialty pharmacy;
- cosmetic drugs
- difference in cost between a generic product and brand product when the medical professional has not specified a brand product or has not indicated that the brand product is necessary;
- duplicate services and charges or inappropriate billing;
- glucoWatch products;
- hair growth stimulants and products indicated only for cosmetic use;
- injectable contraceptives;
- nutritional supplements;
- ostomy supplies
- over-the-counter contraceptives;
- over-the-counter products, unless specifically provided under this plan;
- non-specialty implantable medications;
- non-systemic prescription contraceptives (i.e. diaphragm, cervical caps, etc.);

- prescription medications which are administered or dispensed as take home drugs as part of treatment while in the hospital or at a medical facility and that requires a physician's prescription;
- prescription products that are not dispensed by a licensed pharmacist or medical professional;
- prescription products dispensed in a foreign country if you traveled solely for the purpose of reimporting prescription drugs into the United States and/or you used other means to ship or bring prescription products from a foreign country into the United States;
- prescription products that may be received without charge under local, state or federal programs, including worker's compensation;
- prescription products that require Prior Authorization or any other clinical process in which the prescription was denied or was needed and not requested;
- prescriptions and prescription refills which exceed the Plan's quantity limits;
- prescriptions or supplies rendered before coverage begins under this Plan or after coverage ends;
- refilling a prescription more than the number specified on the prescription or any refill dispensed after one year from the order of the medical professional;
- replacement prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.

If your requested medication or supply is not covered, in whole or in part, you still have the right to purchase that product, however the entire cost of the product will be your responsibility.

CLAIMING BENEFITS FOR PRESCRIPTION DRUGS LIMITATION OF ACTION

You cannot bring any legal action against BMO Financial Corp. or the pharmacy benefits administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against BMO Financial Corp. or the pharmacy benefits administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against BMO Financial Corp. or the pharmacy benefits administrator. You cannot bring any legal action against BMO Financial Corp. or the pharmacy benefits administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring legal action against BMO Financial Corp. or the pharmacy benefits administrator you must do so within three years of the

date you are notified of the final decision on your appeal or lose any rights to bring such action against BMO Financial Corp. or the pharmacy benefits administrator.

MANDATORY VENUE

Any lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to the Plan must be brought to federal court in Cook County, Illinois. The federal courts governing Cook County, Illinois, along with the United States Supreme Court, have exclusive jurisdiction over all disputes arising out of or in any way relating to this Plan.

CLAIM DENIALS AND APPEALS

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the decision made on appeal, you may request in writing, within 90 days of receipt of notice of the decision, a second-level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal or your adverse benefit determination notice or final adverse benefit determination notice does not contain all the information required under ERISA, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non -urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receiving receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receiving the information. If you don't provide the needed information within the 48-hour period, your claim will be deemed denied.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call 1-800-864-1135 or send a written request to:

Attn: Urgent Appeals Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding. You also have the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if your appeal is denied or your adverse benefit determination notice, or final adverse benefit determination notice does not contain all the information required under ERISA. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

If your claim is denied, you will receive a written notice within 30 days of receipt of the claim, if all the information needed is provided with the claim. You will be notified within this 30-day period if additional information is needed to process the claim and a one-time extension not longer than 15 days may be requested and your claim pending until all information is received. Once you are notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be deemed denied.

If you are not satisfied with the decision regarding your benefit coverage or your claim is deemed denied, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription

relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063