SUMMARY PLAN DESCRIPTION
FOR
ELIGIBLE EMPLOYEES AND LTD PARTICIPANTS
(AND THEIR ELIGIBLE DEPENDENTS)
IN THE
EVONIK CORPORATION PRESCRIPTION DRUG PLAN
Effective January 1, 2021

This document is the Summary Plan Description (SPD) for the Evonik Corporation Prescription Drug Plan (the Plan) for non-union and union Employees of Evonik Corporation and former Employees receiving benefits under the Evonik Long Term Disability Program. This SPD outlines the rights and benefits of Covered Persons and their Dependents and describes the major provisions of the Plan as in effect on January 1, 2021. This booklet, together with the Evonik Active and LTD Base SPD will constitute the entire SPD for the Prescription Drug Plan. Eligibility for the Prescription Drug Plan, as well as important legal information is located in the Evonik Active and LTD Base SPD. Prescription Drug Plan benefit details are in this booklet.

The Plan is a participating Plan under the Evonik Corporation Consolidated Welfare Benefits Program (the Program), sponsored by Evonik Corporation (the Company). The Plan provides prescription drug benefits to eligible Covered Persons (defined in the Definition Terms section) of the Company and its participating Employer affiliates. You may check with Mercer Marketplace to verify that your employer is a participating Employer at 1-855-684-6628, Monday through Friday, 7:00 am to 9:00 pm, ET.

This SPD is intended to explain the terms of the Plan in non-technical, everyday language, but capitalized terms and phrases have specific meanings within the context of the Plan. These special capitalized terms are defined in the Defined Terms section at the end of this SPD. The Defined Terms section acts like a glossary.

The complete terms and conditions of the Plan are described in a complex legal Program document. Plan benefits are paid only if provided for in the official Program document. If there are any differences between this SPD and the official Program document, the Program document will govern.

The terms “you” and “your” as used in this Summary Plan Description refer to an Covered Person of the Company or a participating Employer who meets all the eligibility and participation requirements under the Plan (and, with respect to certain benefits rights and participant obligations under the Plan, the Covered Person’s Dependents. Receipt of this SPD does not guarantee that the recipient is a Covered Person under the Plan and/or otherwise eligible for benefits under the Plan**.**

GENERAL PLAN INFORMATION

Introduction

Participation in the Plan will take effect once you enroll in accordance with the Company's procedures. Enrollment is not automatic. If you are an Employee and do not enroll when initially eligible, you must wait until the next annual enrollment to participate in the Plan unless you have a change in status or other event permitting you to make a mid-year election change. These *Election Changes During the Year* may be found in the Active and LTD Base SPD. If you are an LTD Participant and you do not enroll when first eligible, you will not be eligible to enroll in the Plan at a later time. The Plan provides benefits only for the expenses incurred by Covered Persons while the Plan is in effect. No benefits are payable for expenses incurred before the Plan began or after the Plan is terminated. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

All benefits described in this SPD are subject to the exclusions and limitations in this Plan including, but not limited to, the Claims Administrator's determination that care and treatment is necessary according to generally accepted medical standards of care as defined by the Claims Administrator.

The coverage and benefit levels described in this document are subject to change. Please contact the Mercer Service to confirm cost and coverage information. Benefits under this Plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them.

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This Plan provides minimum essential coverage.

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). Each coverage option offered under the Plan meets the minimum value standard for the benefits it provides.

The Plan is administered by third party Claims Administrators on behalf of the Plan Administrator.

Express Scripts (ESI) administers the Prescription Drug Program for Active and LTD participants enrolled in the following medical plan options:

- Aetna – Choice Plus HSA
- BCBS of AL – Premium
- BCBS of AL – Core
- BCBS of AL – Choice Plus HSA
- BCBS of AL – Choice Plus Value HSA
- United Healthcare (UHC) – Choice Plus HSA

Prescription drug benefits are administered separately from the medical benefits component of the Plan, however, for purposes of the deductibles and out-of-pocket maximums, the pharmacy benefit and medical benefits are combined.

Note: If you are enrolled in the CDPHP or Independent Health, the Express Scripts Prescription Drug Program does not apply to you. You will receive your Prescription Drug benefits through your insured HMO.

The Plan covers only Medically Necessary prescriptions and related supplies that are provided for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental illness, substance abuse or symptoms subject to the terms and conditions of the Plan. In this SPD, some drugs will be designated by Express Scripts as "generic", "brand-name" "specialty" or a specific "tier." Drug designation may change, even during the Plan year. For the most current information on a specific drug, you should contact Express Scripts directly.

Prescription drug coverage is subject to drug coverage guidelines developed and modified over time based upon daily or monthly limits as recommended by the Food and Drug Administration, the manufacturer of the drug, and/or peer-reviewed medical literature. To be eligible for benefits, drugs must be legend drugs prescribed by a physician and labeled, "Caution: Federal Law prohibits dispensing without a prescription." Even though your physician has written a prescription for a drug, limitations for prescription drug coverage may apply (i.e., prior authorization and/or quantity duration and/or dispensing quantity limitations and/or age limitations). The guidelines in some instances require you to obtain prior authorization as to the medical necessity of the drug. Your in-network pharmacist and physician should help you comply with the drug coverage guidelines. Refer to the "*Prior Authorization*" section for additional information.

The dispensing quantity rule limits quantity of drug per one copayment/coinsurance. The quantity is based primarily on the common uses of a drug and how frequently it is administered. The quantity duration rule prevents coverage of excessive quantities of drug within a defined time interval. These rules evaluate the quantity of drug requested on the incoming claim in conjunction with prior claims submitted within a specific period of time.

Quantity duration rules alert the pharmacist when the total quantity over time exceeds that for which the Plan normally provides coverage.

Express Scripts retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the *Claims Procedures* section of this SPD.

You will maximize your benefits under the Prescription Drug Program when you purchase medications at a participating pharmacy (you must present your Express Scripts Prescription Drug Program ID card) and use the Express Scripts Pharmacy mail-order service or a Smart90 retail pharmacy instead of a retail drugstore for maintenance medications. Refer to "*When should a retail pharmacy be used?*" and *"When should the home delivery or Smart90 pharmacy be used*" sections for more information. Express Scripts cannot guarantee the availability or

continued network participation of a particular pharmacy. Either Express Scripts or any pharmacy may terminate the provider contract.

Additional information about the Prescription Drug Program is available through Express Scripts Member Services at 1-877-657-2496 or for TTY/TDD users call 1-800-759-1089**.** A directory of Participating Pharmacies under the Prescription Drug Program is also available on www.express-scripts.com.

Cost Sharing Information for In-Network Benefits

	BCBS AL Premium PPO	**BCBS AL Core**	**BCBS AL, Aetna, UHC Choice Plus HSA**	**BCBS AL Choice Plus Value HSA**
Retail - Up to 30 day supply (acute medications and first three fills of a maintenance medication				
Generic	$10 copay	30% after deductible	30% after deductible	30% after deductible
Preferred Brand	$25 copay	30% after deductible	30% after deductible	30% after deductible
Non-preferred Brand	$45 copay	30% after deductible	30% after deductible	30% after deductible
Smart 90 - Walgreens/CVS & Home Delivery - Up to a 90 day supply				
Generic	$20 copay	$0	$0 after deductible	$0 after deductible
Preferred Brand	$50 copay	$40 copay	$40 after deductible	$40 after deductible
Non-preferred Brand	$90 copay	$100 copay	$100 after deductible	$100 after deductible

The BCBS PPO Premium plan does not have out-of-network prescription drug coverage. The BCBS Core, Aetna BCBS, UHC Choice Plus HSA and the BCBS Choice Plus Value HSA have out-of-network prescription drug benefits for retail only.

Prescription drug benefits are administered separately from the medical benefits component of the Plan, however, for purposes of the deductibles and out-of-pocket maximums, the pharmacy benefit and medical benefits are combined.

	BCBS AL Premium PPO		**BCBS AL Core**		**BCBS AL, Aetna, UHC Choice Plus HSA**		**BCBS AL Choice Plus Value HSA**	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible								
Employee Only	$200	$500	$400	$600	$1,400	$1,400	$1,400	$1,400
Employee + 1	$400	$1,000						
Employee + Family	$600	$1,500	$1,200	$1,200	$2,800	$2,800	$2,800	$2,800
Annual Out-of-Pocket Maximum (Includes Deductible)								
Employee Only	$2,000	$4,800	$2,400	$3,600	$3,200	$3,200	$5,500	$5,500
Employee + 1	$4,000	$9,600						
Employee + Family	$6,000	$14,400	$4,800	$7,200	$4,600	$4,600	$11,000	$11,000

* Out-of-pocket limits protect you in case you or a family member has a condition that requires prescriptions that would be very expensive. The limit is the most you would ever pay out of your pocket for prescription drug expenses. Once your payments reach the limit, the plan pays 100% of your prescription drug expenses for the rest of the year. Both medical and pharmacy benefits are combined for purposes of out-of-pocket limits and deductibles.

Prescription Plan FAQs

What is covered?

The Plan's prescription benefit covers a wide variety of prescription drugs, including generic drugs and Preferred brand-name drugs. The Plan also maintains a formulary, which is a list of preferred drugs that members can obtain for lower copays and to help save them money.

An expert panel of physicians and pharmacists carefully reviews the drugs on the formulary for safety, quality, effectiveness and cost. The list includes medications from most major pharmaceutical manufacturers. The formulary and conditions of drug coverage under the Plan is subject to change. To find out whether a particular medicine is included on the formulary or covered under the Plan, and what conditions of coverage (if any) may apply, go to express-scripts.com or call Express Scripts Member Services. A pharmacist can also check whether a medication is on the formulary or covered at any time. Use of a formulary drug is voluntary. However, you will pay less if you use a drug on the formulary than you would for a Non-Preferred Brand drug.

Other Covered Prescription Drug Expenses

The following Prescription Drugs, medications and supplies are also covered Prescription Drug expenses under the Plan:

Off-Label Use

FDA-approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication must have been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in Express Scripts' sole discretion, be subject to Express Scripts requirements or limitations.

Affordable Care Act Preventive Prescription Drugs

The following preventive prescription drugs are covered at 100% with no copay or coinsurance. Note: The government guidelines are updated periodically to reflect new scientific and medical advances, so this list may be subject to change. Please refer to the health reform website www.healthreform.com for additional information.

Preventive Medications

- Aspirin (to prevent cardiovascular events) for adults 50-59 with a high risk of cardiovascular event.
- Aspirin for Preeclampsia for women of childbearing age who are at an increased risk of preeclampsia after 12 weeks gestation – Generic over the counter products = (81mg) of aspirin.
- Bowel preparation for colonoscopy screening – Generic and Brand Prescription, if Generic is not available, and over the counter preparations for men and women ages 50 to 75.
- Contraceptives – Barrier contraception – i.e. caps, diaphragms; Generic and select brands

if a generic is not available, hormonal contraception; emergency contraception; implantable medications.

- Intrauterine contraception; Over the Counter only for morning after pill, Plan B, Ella and prescription contraceptives and patient education and counseling for all women with reproductive capacity. Refer to the below Contraceptive section for plan limits.
- Folic Acid– Generic over-the counter and prescription products 0.4 – 0.8 mg (prescription for over the counter strength is required) for women who are thinking of getting pregnant - For females age 55 and under.
- Fluoride - Generic over-the-counter and prescription products with a Prescription for children to prevent dental cavities - Coverage includes Covered Persons over 6 months of age through the age of 5 years.
- Primary Prevention of Breast Cancer – Generic tamoxifen, generic raloxifene, and brand Soltamox (tamoxifen oral solution) – Asymptomatic women > 35 years who meet authorization criteria.
- Statins – Generic only for adults age 40 to 75 years with no history of cardiovascular disease (CVD), one or more CVD risk factors and a calculated 10-year CVD event risk of 10% or greater.
- Tobacco cessation – All FDA approved prescription products – quantity limit of 180 days' supply within a 365 day period. Copays and coinsurance, as applicable per your medical plan option, apply after the 180 days' supply. Tobacco cessation over the counter (OTC) drugs are not covered.
- Vitamin D - Generic over-the-counter and prescription Vitamin D23 or D3 products containing 1,000 IU or less per dosage form - For men and women ages 65 or over who are at increased risk for falls.

Note: If you are enrolled in a Choice Plus HSA medical option, you can find a complete list of preventive prescription drugs that do not require a deductible on www.express-scripts.com.

Contraceptives

Only the following contraceptives are covered under the Prescription Drug Program and only when purchased at a retail participating pharmacy or through Express Scripts by mail:

- Contraceptive medication – Oral, including Swasonale, Seasonique, transdermal up to age 50.
- Contraceptive patches- up to age 50. Intravaginal contraceptives - up to age 50.
- Implantable contraceptives and IUDs are covered when obtained from a Physician. The Physician will provide insertion and removal of the drugs or device - up to age 50.

The number of copays/coinsurance/deductibles you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30-day supply, will be based on the 90-day supply level.

Dermatologicals

- The Prescription Drug Program covers dermatological prescription drugs. Medications for Tretinoins/Tazorac in all dosage forms coverage requires prior authorization and is only covered for ages 36 and older.

Diabetic Disposable Supplies

- The Prescription Drug Program covers insulin and diabetic supplies prescribed by a

physician including insulin needles, syringes, lancets/lancing devices, alcohol swabs, blood and urine testing supplies, blood glucose monitors (Glucowatch) and continuous glucose monitor (one monitor per Calendar Year) and hyperglycemic products (insta-glucose). These supplies may be obtained from a participating pharmacy, a non-participating pharmacy (depending on the medical option), or through Express Scripts by Mail.

- Oral Anti-Diabetic Agents, insulin Syringes/needles and or diabetic supplies dispensed on the same day require only one copay or coinsurance. The needles and syringes may be purchased in maintenance quantities under the Prescription Drug Program. Insulin pumps and supplies, however, are not covered under the Prescription Drug Program, but they may be covered elsewhere under the Plan.

Oral and Self-Injectable Infertility Drugs

The following Prescription Drugs used for the purpose of treating Infertility, including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Impotency Treatment Drugs

Impotency treatment Prescription Drugs are covered for males age 18 and older based on medical necessity. Erectile dysfunction drugs have a quantity restriction of 8 units per 30 days or 24 units per 90 days. The Prescription Drug Program provides coverage for prescription-only impotency treatment drugs, such as:

- Caverject
- Edex,
- MUSE,
- Viagra, Cialis, Levitra

Tobacco cessation – All FDA-approved prescription products – quantity limit of 180 days' supply within a 365 day period. Copays and coinsurance, as applicable per your medical plan option, apply after the 180 days' supply. Tobacco cessation over the counter (OTC) drugs are not covered.

Pharmacy Benefit Limitations

The following drug categories listed are subject to quantity duration and/or dispensing quantity limitations. The drug categories listed are subject to change and not all medications in each drug category are subject to these rules. To determine if a medication is subject to benefit limitations either call Express Scripts at 877-657-2496 or visit www.express-scripts.com

Immunizations

Brand immunological agents prescribed for prevention of vaccine-preventable diseases when administered in a participating Express Scripts pharmacy setting. These includes non-routine and routine vaccines recommended by ACIP. Zero copay applies to children & adults of varying ages depending on the vaccine. To determine the coverage of your immunizations, contact Express Scripts at 877-657-2496 or visit www.express-scripts.com

What is not covered?

Some drugs are not covered, or excluded, from the prescription drug benefit, which means there are no alternatives to try or exceptions to coverage. The following list of benefit exclusions outlines general categories of items not covered under the Plan. Other drugs may be excluded from the formulary, as noted elsewhere in the Summary Plan Description. To check whether a medication is excluded, go to express-scripts.com or call Express Scripts Member Services.

- A drug which is not medically necessary, including any drugs given in connection with a service or supply, which is not medically necessary.
- A replacement for lost or stolen drugs.
- Any refill that is made more than one year after the latest prescription was written.
- Any refill that is more than the number of refills ordered by the physician.
- Any charges shown as excluded under the BCBS AL Premium, BCBS Core, BCBS Choice Plus HSA, BCBS Choice Plus Value HSA, Aetna Choice Plus HSA and UnitedHealthcare Choice Plus HSA medical option, as applicable that is not covered under the Prescription Drug Program.
- Appetite suppressants, dietary supplements, and vitamin supplements. (This exclusion does not apply to prenatal vitamins which require a prescription and prescription vitamin supplements containing fluoride, which are covered under this Plan.) Anti-obesity medications are covered with a prior authorization. Prescription vitamins are covered.
- Charges above the negotiated charge.
- Charges for giving or injecting drugs.
- Charges for supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy. Prescription drug coverage for Yohimbine is an excluded drug. This exclusion also applies to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in the SPD.
- Charges for over the counter contraceptive supplies, including but not limited to: condoms, contraceptive foams, jellies and ointments; and services associated with the prescribing, monitoring and/or administration of contraceptives.
- Charges for performance, athletic performance, or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in this SPD.
- Charges for any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such Prescription Drugs or supplies outside the United States is considered illegal.
- Drugs and medicines provided (or that can be obtained) without a prescription from a physician.
- Drugs determined by the FDA to be less than effective. These drugs are identified on the FDA's most recent list of "DESI Drug Products and Known Related Drug Products That Lack Substantial Evidence of Effectiveness and Are subject To A notice Of Opportunity for Hearing and Those That Already Have Had Approval Withdrawn."
- Drugs which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written.
- Drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States.

- Drugs used for experimental or investigative treatments or procedures, including services that are part of a Clinical Trial.
- Drugs in excess of the following limits:
  - A 30-day limit for drugs obtained from a retail participating pharmacy, or
  - A 90-day limit for drugs obtained through Express Scripts by mail or the Smart90 program.
- Drugs or shots to prevent disease or allergies (for example, vaccines strictly for travel and diseases, allergy serums.)
- Drugs taken at the same time and place where the prescription is ordered.
- Drugs used to promote hair growth.
- Cosmetic drugs, even if ordered for non-cosmetic purposes. Botox drug category (has medical reasons but can be used for wrinkles) and Tretinoin (used for acne but can be used for wrinkles) are covered with prior authorization to ensure use only for non-cosmetic reasons.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Fluoride supplements - except for prescription fluoride and Topical Rx fluoride (dental) are covered per clinical guidelines.
- Growth hormones except if approved with prior authorization.
- Immunization agents, vaccines, biologicals, blood or blood plasma (these may be covered under Experimental drugs or drugs labeled “Caution — limited by federal law to investigational use.” Unless otherwise noted within this description.
- Injectable medications that cannot be self-administered, unless approved by Express Scripts. (This exclusion does not apply to insulin.)
- Medication for which the cost is recoverable under any workers’ compensation or occupational disease law, any state or governmental agency or medications furnished by any other drug or medical service for which no charge is made to the participant.
- Medication that is taken by or administered to an individual while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution that operates or houses a facility dispensing pharmaceuticals on its premises. This includes take home medication.
- Non-specialty implantable medications
- Nutritional dietary supplements, unless administered intravenously or through a gastrointestinal tube.
- Ostomy supplies
- Progesterone suppositories.
- Tobacco cessation drugs that can be obtained without a physician’s prescription, including nicotine products such as nicotine gum and nicotine patches, and
- Therapeutic devices or appliances, including colostomy supplies and support garments, regardless of intended use. These are not considered prescription drugs and may be covered elsewhere under the Plan. (This exclusion does not apply to disposable insulin needles, syringes, lancets, swabs and strips which are covered under this Prescription Drug Program)

To see if a drug is covered on the formulary, *go to express-scripts.com or call Express Scripts Member Services.*

What is the difference between generic and brand-name drugs?

Generic drugs have the same active ingredients in the same dosage form and strength as their brand- name counterparts. The color and shape may differ between the generic and the brand drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand drugs. The formulary (the list of preferred drugs) chosen by the Plan contains

only FDA-approved generic medications.

Preferred brand drugs, also known as formulary drugs, are medications that have been reviewed and approved by a group of physicians and pharmacists and have been added to the Express Scripts formulary selected by the Plan based on their proven clinical and cost effectiveness.

Non preferred brand drugs, or non-formulary drugs, are medications that the same team of physicians and pharmacists have not approved for the Express Scripts formulary selected by the Plan. This happens when the team determines that a clinically equivalent and more cost-effective alternative generic or preferred brand drug is available.

The formulary changes from time to time as new clinical information becomes available. To determine the status of any particular drug on the Plan's formulary, log onto express-scripts.com or contact Express Scripts Member Services. A medication's inclusion on the formulary is no guarantee of effectiveness.
Similarly, if a medication is not on the formulary, it does not mean it is not effective, but rather that a clinically equivalent and more cost-effective alternative is available and on the formulary. Coverage of prescription drugs may, in Express Scripts' sole discretion, be subject to Express Scripts requirements or limitations. Prescription drugs covered by this Plan are subject to drug utilization review by Express Scripts and/or your physician and/or your network pharmacy.

Your prescription drug benefit coverage is based on the Express Scripts preferred drug guide. The preferred drug guide includes both brand-name prescription drugs and generic prescription drugs. The amount of your copay or coinsurance, after any applicable deductible, is based on if the prescription is filled at a participating pharmacy, the Express Scripts Pharmacy mail-order service or a non-participating pharmacy as well as if the drug is dispensed as a generic drug, preferred brand or a non-preferred brand drug. Generic prescription drugs may be substituted by your pharmacist for brand name prescription drugs. You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available. When you purchase a prescription drug at a participating pharmacy, depending on the medical option that you are enrolled in, you will pay a copay or coinsurance percentage of the medication's contracted price for a brand name drug, non-preferred brand or generic drug. Therefore, the contracted price of the medication will directly impact the amount you may pay out-of-pocket. If the contracted price of the drug is less than the stated minimum, you pay only the contracted price of the drug.

How are claims paid?

Generally, members do not need to submit claims under the prescription plan. A member pays the copay, coinsurance or other amount required by the Plan when filling a prescription. However, if a member needs to submit a paper claim for reimbursement for payment of the cost of a covered drug (for example, if the pharmacy's computer system was not working or the card was left at home), the member downloads a claim form from the website or call Express Scripts Member Services.

When should a retail pharmacy be used?

The retail pharmacy is the most convenient option when a medication is needed immediately, such as an antibiotic for a short-term illness or infection. Members simply present their ID card to the pharmacist, along with the doctor's written prescription if it has not been sent electronically, to receive a 30-day supply of the medicine.

Express Scripts's retail pharmacy network includes more than 70,000 participating pharmacies, including national chains as well as independent retailers.

Some plans may not cover a medication filled at a neighborhood pharmacy because it is not "in network," but the medication will be covered at a large retail pharmacy chain or grocery store if those pharmacies are "in network." If you use a participating retail pharmacy, your out-of-pocket costs will usually be less. To find a participating retail pharmacy, members can visit express-scripts.com and use the Pharmacy Locator to find a list of pharmacies close to where they live or work. Members can also download the

Express Scripts mobile app to find a pharmacy when they're on the go. To download the mobile app for free, search for "Express Scripts" in smartphone app stores. If members do not have computer access, they can call Express Scripts Member Services.

Under the BCBS of AL Premium medical plan option, prescriptions filled at a nonparticipating retail pharmacy are not covered under the Plan, which means if members fill prescriptions there, they pay the full retail price (or 100% of the cost) of the drug and the amount paid does not count against the Plan's deductible or out-of-pocket maximums.

Under the Aetna, BCBS of AL, UnitedHealthcare Choice Plus HSA, and BCBS of AL Choice Plus Value HSA, and the BCBS Core medical options, prescriptions filled at a non-participating retail pharmacy are covered at (70% of the cost) of the drug after the deductible, and the amount paid does count towards the Plan's deductible and out-of-pocket maximum.

When should the Smart90 program retail pharmacy be used?

Smart90

Smart90® requires members to fill maintenance medications for 90 days at a Smart90 retail pharmacy or through the Express Scripts Pharmacy often for a lower cost than they would pay at a retail pharmacy.

Exclusive Smart90

Exclusive Smart90 allows members three 30-day courtesy fills for prescriptions taken on a regular basis for long-term conditions (maintenance medications) at any network pharmacy before a member penalty is triggered. Once the member has used their three courtesy fills, the member must switch to a 90-day supply at a Smart90 Walgreens or CVS Retail pharmacy or at the Express Scripts home delivery pharmacy, or pay 100% of the prescription cost.

When should the home delivery pharmacy be used?

Express Scripts offers home delivery, or a mail pharmacy service, for prescriptions taken on a regular basis for long-term conditions, such as asthma, depression or high blood pressure. With home delivery, members can receive up to a 90-day supply of medicine from the Express Scripts Pharmacy℠, often for a lower cost than they would pay at a retail pharmacy. When you first begin taking a new medication that is prescribed for regular long-term use, you may want to initially fill your prescription at a participating retail pharmacy rather than order a large supply through the mail pharmacy service. This safeguards you against wasting a 90-day supply that you may be unable to use if your physician changes the medication or dosage.

If you or a family member will be traveling outside the country or will need a supply exceeding 90 days, Express Scripts will need to know prior to ordering the medication. Claims exceeding the 90-day limit will be rejected unless there is a drug specific prior authorization on file alerting the pharmacist. Contact Express Scripts Member Services to make a request for a travel abroad or vacation override.

Home delivery advantages

- Fewer refills and fewer trips to the pharmacy
- Free standard shipping costs included as part of the Plan
- Medicine is delivered in tamper-proof, weather- resistant packages
- Drugs that require refrigeration are shipped in cold packs
- Pill bottles have child-resistant safety caps, but easy-open caps may be requested when the order is placed

Express Scripts offers members a variety of convenient ways to submit new prescription orders.

- New prescriptions may be submitted directly from the doctor's office or through the mail.
- Refills can be ordered electronically using the Express Scripts mobile app or website, through the mail or by phone.

Visit express-scripts.com to learn more.

When should the Accredo pharmacy be used?

Specialty Care Drugs

Exclusive Accredo - Exclusive Specialty Drugs: In some cases, the Plan requires the use of Accredo as the sole drug provider for a drug to be covered under the Plan. Through Exclusive Specialty, members are required to obtain their specialty medications through an Express Scripts specialty pharmacy, which provides many vital services not available through retail pharmacies. For non-urgent specialty medications, it's optimal to initiate this with the first fill when the member is in greatest need of specialized pharmacy support and therapy education. For medications that require an immediate start, exceptions for retail filling can be made. Certain specialty medications require prior authorization and may also be subject to quantity duration and/or dispensing quantity limitations. Specialty medications include injectable, infusion and oral drugs prescribed to address complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, multiple sclerosis, immune deficiencies, and rheumatoid arthritis.

Conditions and therapies for which specialty medications are typically used but not limited to are shown below:

Age-related macular degeneration	Growth hormone deficiency	Neutropenia
Alpha-1 antitrypsin deficiency	Hemophilia	Noninfectious uveitis
Anemia	Hepatitis C	Osteoarthritis
Asthma	Hereditary tyrosinemia	Parkinson's disease
Cancer	Homocystinuria	Psoriasis
Crohn's disease	Immune deficiency	Pulmonary arterial hypertension
Crushing disease	Infertility	Respiratory syncytial virus
Cystic fibrosis	Iron chelation therapy	Rheumatoid arthritis
Deep vein thrombosis	Lysosomal storage disorders	Thrombocytopenia
End stage renal disease	Multiple sclerosis	

Refer to the preferred drug guide for a list of specialty care drugs on http://www.accredo.com/home.html. The list may be updated from time to time.

To fill a specialty prescription, you can mail your prescription to the Express Scripts Pharmacy mail-order service. You can also contact Express Scripts Member Services and you will be transferred to an Accredo representative who will help you start the process for obtaining your specialty drugs. You can also provide your physician with your member ID number and ask him or her to call Express Scripts Member Services for instructions on how to use Express Scripts' fax service. Once the Physician calls or faxes the new prescription to Accredo, one of Accredo's patient-care representatives will call you to arrange a time to deliver your medication. Your shipment should arrive within 5 to 8 days after Accredo receives the fax from your Physician and confirms a delivery time with you.

When your medication is getting low, an Accredo representative will make a refill reminder to call you to arrange for your next shipment.

What is SaveonSP?

SaveonSP works in conjunction with the Evonik's current pharmacy program through Express Scripts and Accredo. The SaveonSP program leverages provisions of the Affordable Care Act to maximize copay assistance for certain specialty medications that meet the program requirements. This program is designed to help members save money on their specialty medications by taking advantage of funds available through drug manufacturers.

When filing a specialty medication with Accredo, you may be directed to SaveonSP if the medication is eligible under the SaveonSP program. A participant is eligible to enroll in the SaveonSP program if they currently take certain specialty pharmacy medications that are considered non-essential health benefit specialty medications under the Plan. The SaveonSP program includes 80+ non-essential health benefit medications covering conditions such as hepatitis C (Hep C), multiple sclerosis (MS), psoriasis, inflammatory bowel disease (IBD), rheumatoid arthritis (RA), cancer and others. To receive the most current listing of these medications, call SaveonSP (800) 683-1074.

Enrollment in this program is voluntary; however, SaveonSP cannot ensure the application of manufacturer's dollars at the time of purchase unless you enroll in the program. Additionally, if participate in the SaveonSP program, note that the cost of your medication will not be applied to your deductible, copay and coinsurance. If you choose not to enroll in the SaveonSP program will need to call Express Scripts so that your medication can be processed in accordance with copay, deductible and coinsurance that applies to your medical plan.

Pharmacy Program Descriptions

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. To determine if your medication has any quantity limits either call Express Scripts at 877-657-2496 or visit www.express-scripts.com

Formulary Overview: Clinically sound, cost-effective Express Scripts formulary options help decrease prescription drug expenses when combined with a well-designed benefit plan. 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.

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 similar to 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. If the prescription is denied, you can talk to your Physician about alternative prescriptions that may be covered. You have the right to appeal the decision. Refer to the "Claims Procedures" section for more information. If there is a limit on the amount of medication covered, your pharmacist will fill your prescription up to the amount allowed. If the prescription exceeds the amount covered by the Plan, Express Scripts will tell the pharmacist whether a review might help you obtain coverage for the additional amount.

The following drug categories listed are subject to prior authorization and will require pre-approval. Please note that the medications and drug categories listed are subject to change. In addition to medications requiring prior authorization, certain medications are also subject to quantity duration and/or dispensing quantity limitations and/or age limitations. To determine if a medication is subject to prior authorization either call Express Scripts at 877-657-2496 or visit www.express-scripts.com

Step Therapy is a program for people who take prescription medicine regularly to treat a long-term condition, 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.

To determine if your medication is subject to step therapy either call Express Scripts at 877-657-2496 or visit www.express-scripts.com.

Advanced Opioid Management Program

The Advanced Opioid Management Program is a comprehensive solution that reduces excessive and inappropriate opioid prescribing, particularly for those taking the opioid for the first time. The program puts members in greater compliance with the U.S. Centers for Disease Control guidelines recommended to address this national epidemic through safe opioid prescribing.

Express Scripts SafeGuardRx℠ is a suite of solutions designed to protect plan sponsors and members against rising drug costs, while providing access to specialized therapies and care. It includes the following programs:

Hepatitis Cure Value Program® (HCV)

Members obtain their medication exclusively from Accredo, an Express Scripts specialty pharmacy. Express Scripts research shows that the percentage of hepatitis C patients who stop therapy is reduced by 50% when members fill their prescriptions at Accredo, with a 96% cure rate. Once enrolled, members who are new to therapy and who receive a prescription for Viekira Pak® will be instructed to obtain their first and subsequent fills through Accredo, with no available fills at retail. Express Scripts notifies physicians of this requirement to ensure initial prescriptions are directed to Accredo. Members who are already on an existing therapy may continue their course of treatment through their current pharmacy.

Cardiovascular Care Value Program® (CCV)

Prescriptions are dispensed using a clinical days' supply rule, which provides three 30-day prescriptions to ensure therapy tolerance before moving to a 90-day fill. Accredo provides members with care assistance, including assistance from the extensively trained specialist pharmacists in the Cardiovascular Therapeutic Resource Center who can help improve adherence compared to other pharmacies.

Oncology Care Value Program℠ (OCV)

This program aligns the cost of a drug to its efficacy for specific types of cancer and helps ensure members get the medications they need at the right price. It includes a rigorous clinical review process by a dedicated clinical team at Express Scripts and specialist pharmacist support through the Oncology Therapeutic Resource Center. The program focuses on medications for prostate cancer, lung cancer and renal cell carcinoma and has laid the foundation to expand to other cancers and therapy classes in the future.

Inflammatory Conditions Care Value Program℠ (ICCV)

To provide optimal care and value, members will fill prescriptions for their inflammatory conditions exclusively through Accredo specialty pharmacy and will receive support from the highly trained specialist pharmacists and nurses in the Inflammatory Conditions Therapeutic Resource Center.

Rare Conditions Care Value℠ Program

The Rare Conditions Care Value℠ (RCCV) program combines clinical specialization and cost containment tools for conditions that pose the greatest challenges, such as acromegaly, alpha-1 deficiency, Gaucher's disease, hemophilia, hereditary angioedema, Huntington's disease, and idiopathic pulmonary fibrosis. The program is designed to adapt to a rapidly changing landscape, and whenever we need to expand to additional rare conditions, we will.

Reviews and Appeals

Initial coverage review

A member has the right to request that a medicine be covered or be covered at a higher benefit (such as a lower copay or higher quantity). 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 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 express-scripts.com/PA.

To request an initial administrative coverage review, the member or his or her representative must submit

the request in writing using a **Benefit Coverage Request Form**, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

Complete the form and fax it to 877.328.9660 or mail to:

Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

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 attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability 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 patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at 800.753.2851.

How an initial coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision	
		APPROVAL	DENIAL
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	**Patient** Automated call (and letter, if call unsuccessful) **Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Letter **Prescriber** Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service*	30 days		
Urgent	72 hours**	**Patient** Automated call and letter **Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Live call and letter **Prescriber** Electronic or fax (and letter, if fax unsuccessful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

** Assumes all information necessary is provided. If information is not provided within 24 hours of receipt, a 48-hour extension will be granted.

Level 1 appeal or urgent appeal

How to request a level 1 appeal or urgent appeal after an initial coverage review is denied

When an initial coverage review has been denied, also referred to as an 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 and administrative appeal requests can be mailed or faxed to the following addresses and fax numbers:

Clinical appeal requests

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

877.852.4070

Administrative appeal requests

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

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 attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability 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 patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. 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:

Urgent clinical appeal requests

800.753.2851 877.852.4070

Urgent administrative appeal requests

800.946.3979 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.

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a pharmacist, physician, panel of clinicians, trained prior authorization staff member or independent third-party utilization management company. Appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	**Patient** Automated call (and letter, if call unsuccessful)	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days				
Urgent*	72 hours	**Patient** Automated call and letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Live call and letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination. In an urgent care situation, only one level of internal appeal is provided prior to an external review.

Level 2 appeal

How to request a level 2 appeal after a level 1 appeal is denied

When a level 1 appeal has been denied, also called an 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

Clinical appeal requests and administrative appeal requests can be sent to the following addresses and fax numbers:

Clinical appeal requests

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

877.852.4070

Administrative appeal requests

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

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 attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability 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 patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. 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:

Urgent clinical appeal requests

800.753.2851 877.852.4070

Urgent administrative appeal requests

800.946.3979 877.328.9660

Type of Claim	Decision Timeframe Decisions are completed ASAP from receipt of request and no later than:	Notification of Decision			
		APPROVAL		DENIAL	
Standard Pre-Service	15 days	**Patient** Automated call (and letter, if call unsuccessful)	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)
Standard Post-Service	30 days				
Urgent*	72 hours	**Patient** Automated call and letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)	**Patient** Live call and letter	**Prescriber** Electronic or fax (and letter, if fax unsuccessful)

* If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

External review

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 (IRO) 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, an independent third party utilization management company, at:

MCMC LLC
Attn: Express Scripts
Appeal Program 300
Crown Colony Drive,
Suite 203
Quincy, MA 02169-0929


617.375.7700, ext. 28253


617.375.7683

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 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, which in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life, 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.

Prescription Plan Definitions

Accredo: An Express Scripts specialty pharmacy.

Acute medication: Drugs taken for a limited time to treat temporary medical conditions or illnesses, such as antibiotics for infections.

Appeal: A review of an initial or first-level appeal denial, along with any additional information provided or available, to determine if the member's use of the drug meets the Plan's intent for coverage. Appeals are related to coverage denials; they are not related to procedures addressing member complaints or grievances. Express Scripts completes appeals according to business policies that are aligned with state and federal regulations. For more information, refer to Process Overviews.

Appeals process: A specific process that a member needs to follow when making an appeal request. Depending on the appeal type, decisions are made by an Express Scripts pharmacist, physician, panel of clinicians, trained prior authorization staff or an independent third-party utilization management company. Members are notified of the decision and of any rights to appeal an adverse benefit decision. For ERISA plans: Under Section 502(a) of ERISA, members have the right to bring a civil action if their final appeal is denied.

Benefit exclusion: Also referred to as "not covered," this includes a drug or drug class that is not included in the member's benefit and means there are no alternatives to try or exceptions to coverage.

Biosimilar: A biopharmaceutical drug designed to have active properties similar to one that has previously been licensed.

Brand: A drug protected by a patent, which prohibits other companies from manufacturing the drug while the patent is in effect, issued to the original innovator or marketer and manufactured by a single source. The name is unique and usually does not describe the chemical makeup (for example, Tylenol®).

Compound: A medicine that is made of two or more ingredients that are weighed, measured, prepared or mixed according to a prescription order.

Copay/coinsurance: The cost of a covered drug paid by the member at the time the prescription is filled and after the deductible is met (if applicable) per individuals or families.

Coverage review: Also known as the initial review or initial determination, this process is followed when a member requests coverage for a drug, or requests coverage for a drug at a higher benefit. It's the first review of drug coverage based on the Plan's conditions of coverage. The initial review decision is based on the information provided by the prescriber (clinical) or the patient (administrative) and the criteria in place. If the initial review is denied, then the patient/representative may appeal the decision.

Covered Person means an Employee or an LTD Participant or a Dependent of those who is covered under this Plan.

Employee means a person who is on the payroll of an Employer. An individual who is classified by an Employer as an independent contractor or other non-employee will not be considered an Employee under the Plan, regardless of whether the individual is deemed by a government agency or a court to be a common law employee of the Employer.
Excluded: Drugs that are not covered and will not be reimbursed by the Plan's pharmacy benefit.

Formulary: A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Products are selected on the basis of safety, efficacy and cost.

Formulary exclusions: Certain drugs are excluded from the formulary. Clinically effective alternatives are available for all excluded products.

Formulary exclusion exception review: The prescriber may request an exception to the formulary exclusion. Express Scripts contacts the prescriber for information to determine if the conditions of coverage are met for an exception to the formulary exclusion. If the formulary exception is denied, the patient or their representative may appeal the decision.

Generic: A drug that has the same active ingredients in the same dosage form and strength as its brand- name counterpart. The color and shape may differ between the generic and brand-name drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand-name drugs. Generic drugs often cost less than brand-name drugs. A generic drug can be produced once the manufacturer of the brand-name drug is required to allow other manufacturers to produce the drug.

Home delivery: A distribution channel in which the member receives a prescription drug through the mail from the Express Scripts Pharmacy℠.

LTD Participant means a former Employee who remains a Covered Person for purposes of the Plan because he or she is receiving long-term disability benefits from the Evonik LTD plan. LTD means long-term disability.

Maintenance medication: Drugs taken over an extended period of time for a long-term condition, such as high blood pressure, depression or asthma. These drugs are typically filled through the home delivery pharmacy for a 90 days' supply to provide members with lower costs and more convenience.

Network pharmacy: A pharmacy (also called a retail network pharmacy) that participates in the Plan's network. In most cases, members need to use a network pharmacy to pay the amounts specified by the Plan.

Non-network pharmacy: A pharmacy not associated with the retail network. Benefits will not be covered at the same rate as a network pharmacy and members will have to pay the full cost of the medication at non-network pharmacies.

Not covered: Also known as “benefit exclusion,” this includes a drug or drug class that is not included in the member’s benefit, which means there are no alternatives to try or exceptions to coverage.

Over the counter (OTC): A drug that is available without a prescription from a doctor.

Specialist pharmacist: An Express Scripts pharmacist who receives extra training in medicines used to treat specific long-term and complex conditions. These pharmacists use nationally accepted, evidence- based procedures and work with physicians to identify gaps in care across different providers. Specialist pharmacists personally counsel patients to help them understand and follow through on their treatments.

Specialty drug: A high-cost drug, including infused or injectable medicines, that usually require close monitoring and special storage. Specialty drugs are generally prescribed to people with an ongoing or complex medical condition.