State of Delaware

Summary of Medicare Part D Prescription Plan Benefits

Calendar Year January 1, 2025 through December 31, 2025

State of Delaware Medicare Part D Prescription Plan

This booklet summarizes and describes the main provisions of the prescription drug plan (Plan) called the **SilverScript Employer PDP sponsored by the State of Delaware** (SilverScript) made available to Medicare Eligible Pensioners and their eligible dependents enrolled in the State of Delaware Group Health Insurance Plan (GHIP). This Plan supplements Medicare Part D prescription drug coverage. This prescription drug plan is provided by SilverScript Insurance Company which is affiliated with CVS Caremark, the pharmacy benefit manager for the State of Delaware (State). **The effective date of this summary is January 1, 2025**.

This is a summary of the most important provisions of the Plan. While this summary should answer most of your questions, it does not provide all the details of the Plan. These can be found in Plan documents maintained by SilverScript. If there is any difference between SilverScript documents and this summary, your rights will be based on the provisions of documents prepared by SilverScript.

We encourage you to read this summary carefully and share it with your family members. If you have any questions about this Plan or your prescription drug benefits, please contact the State of Delaware Office of Pensions at 1-800-722-7300 from 8:00 a.m. to 4:30 p.m., Eastern Time, Monday through Friday or CVS Caremark, the prescription drug plan administrator, directly at 1-844-757-0448 or the Statewide Benefits Office at 1-800-489-8933.

Separate summaries describing other benefits available under the GHIP are available to you and may be obtained by contacting the Statewide Benefits Office at 1-800-489-8933 or at https://de.gov/statewidebenefits.

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About Your Participation

This section includes important information about your participation in the prescription drug plan (Plan), including eligibility information, when to enroll, when you can make election changes, paying for coverage and when coverage ends.

Who Is Eligible?

This Prescription Health Plan is made available through the State of Delaware who elected to provide Medicare Part D Prescription coverage for:

- Retired employees and their spouses
- Disabled employees, spouses and dependent children
- Employees, spouses and dependent children who have End-Stage Renal Disease (ESRD) or Amyotrophic lateral sclerosis (ALS).

You, your spouse and/or dependents must be enrolled in Medicare Part A and Part B to participate in this coverage. You, your spouse and/or dependents must also continue to be covered under both Part A and Part B to keep coverage in this Plan.

You, your spouse and/or dependents may not be enrolled in another Medicare Part D Prescription Plan.

Enrollment Date

Your enrollment date is the effective date of your enrollment in the State of Delaware Medicare Supplement plan with Prescription drug coverage.

How to Enroll

When you select a Medicare supplement plan with prescription drug coverage, you will be automatically enrolled in the Plan. If you do not elect this coverage combination, you would need to wait until the next Annual Medicare Open Enrollment for coverage beginning the following January. Please note that you cannot enroll in prescription drug coverage only; it must be in combination with a Medicare supplement plan.

Enrollments will be processed with a prospective effective date and must be sent a minimum of 30 days in advance of the effective date to ensure members receive all required notifications per the Centers for Medicare & Medicaid Services (CMS) guidelines.

How to Decline Coverage

You may decline medical and prescription drug coverage if you do not wish to enroll when you are first eligible.

Paying for Prescription Drug Benefit Coverage

The cost of the Plan is included in the cost of the State of Delaware medical plan you choose.

A late enrollment penalty may be added to your Medicare Part D Prescription monthly premium if, you go without creditable prescription drug coverage for any continuous period of **63 days or more** after your initial enrollment period is over.

Making Changes during the Year

You may make a benefit or dependent change outside of the Annual Fall Medicare Open Enrollment if you experience an eligible Qualifying Event:

- Marriage or civil union
- Divorce
- Employment of spouse
- Involuntary loss of spouse coverage

Benefit election changes must be made within 30 days of the date of the eligible qualifying event. Additional information regarding Qualifying Events is located online at https://dhr.delaware.gov/benefits.

When Prescription Drug Coverage Ends

Death

Coverage for your surviving spouse and any eligible dependents ends as of the last day of the month of your death.

Loss of Benefits

You can lose coverage under this plan if you do not retain coverage under both Part A and Part B of Medicare.

Persons under 65 can lose their Medicare eligibility by losing their Social Security disability classification. This occurs when the disabled or blind person becomes gainfully employed or, in the case of the dialysis patient, three years after a successful kidney transplant or one year after termination of dialysis.

State Drops Coverage

Your coverage (and your dependents coverage) ends on the date on which the State's contract with us for the provision of benefits ends.

Enrollment in another Part D Plan

The Centers for Medicare & Medicaid Services (CMS) only allows enrollment in one qualified Medicare Part D prescription drug plan. Enrollment in another plan may terminate coverage.

Divorce

Former spouses are not eligible for coverage. Coverage for the former spouse ends on the last day of the month in which the divorce becomes final. You must provide a copy of the divorce decree **within 30 days** of the divorce. Failure to provide notice may result in you being financially responsible for premiums and services provided to your former spouses.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if you have committed an act, practice or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent.

Note: The State of Delaware has the right to demand that you pay back benefits that the State of Delaware paid to you, or paid in your name, during the time you were incorrectly covered under the Plan due to fraud or intentional misrepresentation.

For an explanation of your plan's rules, please refer to the SilverScript member communications. The *Evidence of Coverage (EOC)* lists other instances where membership may end. You can review important documents by visiting https://MyDocumentSource.MemberDoc.com or https://dhr.delaware.gov/benefits/cvs/medicare. All you need to view your documents is your member number found on your member ID card and your zip code. You may also request a copy of the EOC by contacting SilverScript Customer Care at 1-844-757-0448.

Benefits After Your Coverage Ends

If you are an inpatient in a hospital, skilled nursing facility or specialized care facility on the date your coverage terminates because your employer dropped coverage with us, we will continue to provide the benefits described in this booklet for the facility and professional charges related to that admission for up to 10 days after the coverage termination date or until the day you are discharged from the hospital, skilled nursing facility or specialized care facility, whichever occurs first.

If you lose coverage for any reason other than because your employer dropped coverage, all health care benefits under this health care plan terminate on the date your group coverage terminates.

Continuation of Your Plan Coverage

You may be able to continue coverage under the Plan under certain conditions if you choose to continue your State of Delaware health plan coverage.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Under COBRA, group health plans must provide covered employees and eligible dependents with specific notices explaining their COBRA rights, upon initial participation in the plan and when the employee or eligible dependent experiences a COBRA qualifying event. COBRA sets rules for how and when plan sponsors must offer and provide continuation coverage, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

COBRA requires that continuation coverage extend from the date of the qualifying event for a limited period of 18 or 36 months. When the qualifying event is the covered employee's termination of employment (for reasons other than gross misconduct) or reduction in work hours, qualified beneficiaries are eligible for 18 months of continuation coverage. For all other qualifying events, qualified beneficiaries must receive 36 months of continuation coverage.

For questions about your COBRA notice, you may call ASI COBRA at 1-877-388-8331 and through the web at www.asicobra.com.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting this Plan, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Terms You Should Know

Claims Administrator: SilverScript administered by CVS Caremark, as pharmacy benefit manager, provides certain claim administration services for the Plan.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): A federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copay: The fee that must be paid by the plan participant to a participating pharmacy at the time of service for covered prescription drugs.

Coinsurance: A percentage of the charge that must be paid by the plan participant to a participating pharmacy at the time of service for certain covered prescription drugs.

Formulary: A list of FDA-approved generic and brand name prescription drugs that are covered by the prescription drug plan. Plans may have their own formularies.

Medicare Part D: An optional prescription drug benefit for Medicare beneficiaries. Members can only be enrolled in one eligible Medicare Part D plan.

Pharmacy Benefit Management (PBM): A pharmacy benefit manager is a third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.

Prior Authorization: Prior authorization is a management process used by insurance companies to determine if a prescribed product or service will be covered under the Plan. It also ensures that drugs are being prescribed for the appropriate reason and patient.

Utilization Management (UM): Utilization Management (UM) programs review prescription drugs for medical necessity, appropriate use and safety. Common utilization management programs for prescription drugs include prior authorization, quantity limits and required use of lower-cost or generic options before coverage of certain drugs.

SilverScript Part D Prescription Drug Benefits

The drug benefit described in this document is your final benefit after combining the standard Medicare Part D benefit with additional drug coverage being provided by the State of Delaware. Please visit the CVS Caremark website at https://www.caremark.com or call SilverScript Customer Care at 1-844-757-0448 for more information.

Under this Plan, your cost is lower for generic and preferred prescription drugs, which are subsidized at a higher rate.

Under the Plan, you can obtain prescription drugs three ways:

- Through a participating retail pharmacy;
- Through the CVS Caremark® Mail Service Pharmacy for home delivery service;
- Through CVS Specialty® pharmacy.

This Plan does not cover prescriptions you receive from out-of-network pharmacies unless under a travel emergency situation.

For information on network pharmacies, call CVS Caremark Customer Care at 1-833-458-0835 or visit CVS Caremark at https://www.caremark.com. Information is also available at https://de.gov/statewidebenefits.

Generally, the Plan requires that you pay a member cost share for each prescription covered under the Plan when you receive a prescription at the appropriate participating retail pharmacies, through the CVS Caremark® Mail Service Pharmacy or through CVS Specialty® pharmacy.

Member Drug Costs

The amount you pay for your prescription depends on whether the drug is:

- A generic, preferred or non-preferred brand, or specialty drug,
- On the SilverScript Medicare Part D Formulary, and
- Filled at the appropriate participating pharmacy.

The prescription drug summary of benefits shows your share of the drug cost that applies to each category of the prescription drug program:

- Non-Specialty Drugs
  - Generic Drugs
  - Preferred Brand Name (Formulary), and
  - Non-Preferred Brand Name (Non-Formulary)
- Specialty Drugs

Up to a 31-Day Supply (Available at a participating retail pharmacy - including all major chains)		
Non-Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$10 Copay	Not Covered
Preferred Brand Name (Formulary)	$32 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$60 Copay	Not Covered

Up to a 90-Day Supply* (Available at a participating retail pharmacy or through Home Delivery)		
Non-Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$20 Copay	Not Covered
Preferred Brand Name (Formulary)	$64 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$120 Copay	Not Covered

** Not all drugs are available at a 90-day supply. Some retail pharmacies in your plan only provide a one-month supply of your covered prescriptions at the one-month supply copayment*

Up to a 31-Day Supply (Available at CVS Specialty® pharmacy through Home Delivery)		
Specialty Drugs	**In-Network Pharmacy**	**Out-of-Network Pharmacy**
Generic Drugs	$20 Copay	Not Covered
Preferred Brand Name (Formulary)	$64 Copay	Not Covered
Non-Preferred Brand Name (Non-Formulary)	$120 Copay	Not Covered

Formulary Drug List

The Formulary is a list that shows the generic and brand name drugs that are considered preferred drugs. It contains a listing of highly utilized Medicare Part D drugs selected by SilverScript in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary also includes information on requirements or limits for some covered drugs that are part of the SilverScript standard formulary drug rules.

You can reduce how much you have to pay for a prescription by using a covered generic drug or a covered brand-name drug that appears on the Formulary (Preferred). In most cases, your share of the cost will be highest if your physician prescribes a covered brand-name drug that does not appear on the Formulary (Non-Preferred).

For more information on your plan's specific drug coverage, please review your other plan materials, visit the CVS Caremark website at https://www.caremark.com or contact SilverScript Customer Care at 1-844-757-0448.

Compound Medications

Compound medications covered under your prescription plan are created to fit unique member needs by combining or processing appropriate ingredients as prescribed by a physician. For example, the form of a medication may be changed from a solid pill to a liquid, or the medication may be customized to avoid a non-essential ingredient that the patient is allergic to.

- The copay for all compound medications is the tier copay of the most expensive primary ingredient of the compound.
- The ingredients that (1) are not approved by the FDA for use in compounds, or (2) have experienced significant unjustified cost increases, are not covered under your plan. For more information contact SilverScript Customer Care at 1-844-757-0448.
  - If your compound medication includes a non-covered ingredient, your doctor can write a new prescription using only covered ingredients.
  - If there is a medical reason that you must take a non-covered medication, your doctor can file an appeal with a letter of medical necessity.
- Filling a compound prescription:
  - Some compound medications can be filled at an in-network retail pharmacy. Others may need to be filled at an in-network compounding pharmacy. You may want to check with your regular pharmacy before exploring other options.
  - CVS Caremark® Mail Service Pharmacy does not fill prescriptions for compound medications.

If you use an out-of-network compounding pharmacy, you must pay out of pocket for your prescription and submit a direct claim to SilverScript. Depending on why you've used an out-of-network pharmacy, you may be able to receive partial reimbursement based on the maximum allowable cost for the total ingredients. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy.

Specialty Medications

Specialty medications are used to treat complex and chronic conditions like rheumatoid arthritis, multiple sclerosis, psoriasis, rare genetic disorders and cancer. Specialty medications are most often injected or infused. Preferred Specialty Management uses prior authorization and step therapy to ensure that members are taking the most clinically appropriate, cost-effective medication first.

Specialty medications are limited to a 30-day supply, and are required to be filled at a participating CVS Specialty® pharmacy. SilverScript has a nationwide network of specialty pharmacies accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Staff from CVS Specialty® will reach out to physicians and members to work together in managing the member's prescription needs. Specialty medications can be sent to your home or work address, your doctor's office or even a CVS Pharmacy® store(where allowed by law). If your medication has any special storage requirements, the representative will review those with you. CVS Specialty® pharmacy dedicated customer service number is 1-800-237-2767.

Drug Coverage Provided by your State of Delaware Medical Plan

Prescription drugs that are dispensed to you while in a hospital, either as an inpatient or as an outpatient at an approved outpatient facility, or in your doctor's office, are covered under Medicare Part B and your State of Delaware medical plan. You must follow normal medical claim procedures for reimbursement for these drugs.

Coverage Review Programs

Coverage Review

The Coverage Review Process is designed to keep up with changes in the prescription marketplace and ensure that plan participants are receiving prescription medications that result in appropriate, cost-effective care. The coverage review process may be necessary when:

- The medication is not on the formulary or covered under the plan.
- The medication is used to treat multiple conditions.
- The dosage of the medication being prescribed exceeds the FDA (and formulary) limits.
- The medication may be eligible for coverage under Medicare Part B.

If you are taking any drugs that are subject to coverage review, SilverScript will need to review additional information from your doctor before a decision can be made as to whether if the prescription can be covered under the prescription drug plan. Medications listed as not covered by the Plan in the section "Drugs That Are Not Covered" are not subject to clinical review (i.e., would not take into account any additional information from a doctor). Check the Statewide Benefits Office website at www.de.gov/statewidebenefits more information.

Step Therapy

Certain medications may not be covered unless you have first tried another medication or therapy. If a drug has a step therapy restriction and you would like to request an exception, contact SilverScript Customer Care at 1-844-757-0448. If the preferred alternative medication does not show in your prescription history with SilverScript, then your doctor will need to provide additional information before coverage can be authorized.

Authorization for Additional Quantity of Medication

Quantity rules are in place for many medications, and coverage review is required to request additional quantities. In addition, quantities for narcotics and other controlled substances are limited to comply with Federal Food and Drug Administration guidelines. To find out in advance if a drug has a quantity limit, contact SilverScript Customer Care at 1-844-757-0448.

Member Cost Saving Programs

Maintenance Medication Program

Maintenance medications are generally used to control conditions or diseases that are chronic or last for an extended time, such as diabetes, high blood pressure (hypertension), high cholesterol, and asthma. Medications used to treat short term conditions, such as bronchitis, bacterial infections or pain following minor surgery are not eligible under the program.

The Maintenance Medication Program provides prescription cost savings by allowing members to fill 90-day prescriptions at reduced copays, when eligible. When members receive maintenance medications every thirty-one days, they pay three 31-day copays in order to receive a 90-day supply of medication. Under the maintenance medication program, one 90-day prescription costs the same as two 31-day prescriptions.

Members can fill 90-day prescriptions*:

- At a 90-day retail pharmacy that participates in the CVS Caremark network
- Through the CVS Caremark® Mail Service Pharmacy

**Not all drugs are available at a 90-day supply.*

If you have questions, please contact CVS Caremark Customer Care at 1-833-458-0835 or the Statewide Benefits Office at 1-800-489-8933.

Diabetic Medications & Supplies

Diabetic supplies such as lancets, syringes/needles, and test strips provided, either at a participating retail pharmacy, a 90-day participating retail pharmacy, or CVS Caremark® Mail Service Pharmacy may be obtained under the prescription plan at no cost to the member. Supplies do not need to be ordered at the same time as medications to take advantage of the $0 copay.

Diabetic supplies designated as Durable Medical Equipment (DME) are not covered under the prescription plan. These include Continuous Blood Glucose Monitoring Systems (e.g. Free Style Libre and Dexcom), Insulin Pumps and Supplies. Members should contact their medical plan to discuss coverage options for these supplies.

Multiple diabetic medications may be obtained for just one copay when the prescriptions are filled at the same time at a 90-day participating pharmacy or the CVS Caremark® Mail Service Pharmacy, when eligible. To ensure the lowest copayment for covered diabetic medications, make sure to ask the pharmacy to process all diabetic medications on the same day and submit the lowest cost generic medication first.

When multiple diabetic medications are filled and purchased on the same day, you are eligible to pay one copay, but if the doctor in the same month, prescribes another diabetic medication that is filled on a different day, another copay will be assessed.

It is the member's responsibility to work with their physician and pharmacist to coordinate the prescriptions to be processed on the same day. The Plan will not provide adjustments for prescriptions not originally processed on the same day.

For more information on Diabetic Resources, visit
https://dhr.delaware.gov/benefits/medicare/index.shtml.

Transform Diabetes Care Diabetes Monitoring Program

Medicare members have access to a **free** diabetes care management program called Transform Diabetes Care. The program provides members with access to Certified Diabetes Educators to assist with diabetes management decisions and engages with members on actionable steps to address gaps in care, evaluate medical needs and facilitate overall wellness.

For questions and to learn more call SilverScript Customer Care at 1-844-757-0448.

Drugs That Are Not Covered

The following are some of the drugs currently **not covered** under the Plan**:**

- Non-Federal Legend Drugs (OTC) excepted where mandated by ACA
- Investigational drugs
- Prescription drugs that have OTC equivalents
- Ostomy Supplies
- Mifeprex
- Cosmetic & hypopigmentation Drugs
- Plan B One Step
- Anti-Obesity Preparations, Weight Loss Medications (i.e., Saxenda)
- Dental Fluoride Products except where mandated by ACA
- Allergy Sera & Blood Products
- Erectile Dysfunction Agents
- Hypoactive Sexual Desire Disorder (HSDD) Agents
- Continuous Blood Glucose Monitoring Systems (e.g., monitor, transmitter, receiver, sensor)
- Insulin Pumps and Supplies
- Peak Flow Meters and Nebulizers
- Nutritional Supplements
- Select Vitamins requiring a prescription
- Periodontal Subgingival Implants
- Medical Benefit Only Drugs
- Addyi

Additional Coverage

The State of Delaware provides additional coverage on certain medications. The Drug List provided to you includes information for the covered drugs that are most commonly used by members. If one of your drugs is not listed in the Drug List, please use the "check drug cost tool" to confirm coverage and pricing of the drug or contact Customer Care to find out if the drug is covered under your prescription drug plan. You can find a list of these drugs on the State of Delaware Statewide Benefits Office website: https://dhr.delaware.gov/benefits/cvs/medicare/formulary.shtml

If you have any questions regarding your prescription drug coverage, please contact SilverScript Customer Care at 1-844-757-0448 (TTY users only: 711). Customer Service is available 24 hours a day, 7 days a week.

If you qualify for Extra Help

If you qualify for Extra Help from Medicare to help pay for your prescription drugs, your cost- sharing amounts may be lower than your plan's standard benefit. Members who qualify for Extra Help will receive a notice called "Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs" ("Low Income Rider" or "LIS Rider"). Please read it to find out what your costs are. You can also contact SilverScript Customer Care with any questions.

Long-Term Care (LTC) Pharmacy

If you reside in an LTC facility, you pay the same as at a network retail pharmacy. LTC pharmacies must dispense brand-name drugs in amounts of 14 days or less at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact SilverScript Customer Care at 1-844-757-0448, if you have questions about copayment or billing when less than a one-month supply is dispensed.

Out-of-Network Coverage

You must use SilverScript network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You generally have to pay the full cost for drugs received at an out-of-network pharmacy at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Please contact SilverScript Customer Care at 1-844-757-0448 for more details.

Your ID Card

When you first enroll in your State of Delaware medical plan, you will receive an identification card from SilverScript. If you need additional cards, you can request a card by calling SilverScript Customer Care at 1-844-757-0448. You can print a temporary identification card from the CVS Caremark website at https://www.caremark.com. If you are a first-time visitor, take a moment to register using your member ID number or social security number (SSN).

It is important to remember to use your Prescription drug plan ID card at the pharmacy rather than your medical plan's insurance card. **Please Note:** Some prescriptions may require you to provide your Medicare card to the pharmacist as they may be covered under Medicare Part B.

When You Need to Fill a Prescription

When you need to fill a prescription, you can choose to go to your local participating retail pharmacy or, for mail order, use the CVS Caremark® Mail Service Pharmacy. If your prescription is for a 31-day supply of a medication or less, one of the retail options is best. If you are filling a maintenance medication that you are expecting to take for a longer period of time, the CVS Caremark® Mail Service Pharmacy is your best choice. You may also obtain a 90-day supply of a maintenance medication through certain retail pharmacies that participate in the SilverScript network.

Regardless of whether you choose a participating pharmacy or the CVS Caremark® Mail Service Pharmacy, generic drugs are used to fill prescriptions whenever possible, unless your doctor specifies otherwise. The pharmacist may contact your doctor to suggest that a preferred brand- name drug be substituted with a comparable drug from the SilverScript formulary. You and your doctor decide whether or not to switch to the formulary medication.

If you choose to fill your prescription at a non-participating pharmacy, or, in other words, at an out-of-network pharmacy, no benefits are payable from the Plan, and you are responsible for the full cost. If, however, you incur prescription expenses related to an emergency while you are traveling, you may submit a paper claim form along with original receipts, as detailed below in section “When You Need to File a Claim Form.”

Retail Pharmacies

SilverScript has contracted with retail pharmacies, including most major drug stores and local pharmacy locations. These retail pharmacies in the SilverScript network are referred to as “participating pharmacies.” To locate a participating pharmacy close to your home or other location, you can call CVS Caremark Customer Care at 1-833-458-0835 or check CVS Caremark’s website at www.caremark.com. You can purchase up to a 30-day supply at one time at any retail pharmacy. You may obtain a 90-day supply of a maintenance medication through a retail pharmacy that participates in the SilverScript network.

The CVS Caremark® Mail Service Pharmacy

To receive your covered drugs through home delivery, you may sign up online by logging into your https://www.caremark.com account and select “Start Rx Delivery by Mail” OR ask your doctor to send in a new prescription electronically for delivery from the CVS Caremark® Mail Service Pharmacy. (Only your doctor can electronically send prescriptions to CVS Caremark.) Only 90-day supplies of maintenance medications can be obtained through the CVS Caremark® Mail Service Pharmacy. Refills may be ordered online at https://www.caremark.com. For more information, visit https://www.caremark.com/MailService or call SilverScript Customer Care at 1-844-757-0448.

When You Need to File a Claim Form

If you obtain a prescription drug from a non-participating retail pharmacy (i.e., a pharmacy that is not in the SilverScript network) in certain situations, including while you are traveling outside of the plan’s service area and an emergency comes up; you must pay the non-participating pharmacy the full cost of the prescription. Then, you may submit a paper claim form along with original receipts directly to SilverScript for reimbursement of the covered expenses. **Claims must be filed within three (3) years of the prescription fill date**.

To obtain a claim form, call SilverScript Customer Care toll-free at 1-844-757-0448 or visit https://dhr.delaware.gov/benefits/cvs/medicare/index.shtml to view and print a claim form.

You should submit your claim form to:

SilverScript Insurance Company
Prescription Drug Plans
Medicare Part D Paper Claim
P.O. Box 52066
Phoenix, AZ 85072-2066

Your claim will be reimbursed according to the cost-sharing provisions of your prescription drug coverage applicable to prescriptions purchased at a participating pharmacy in the SilverScript network. To find out if your pharmacy is affiliated with SilverScript, for instructions on filing claims, for refills and for status of an order, call SilverScript Customer Care toll-free at 1-844-757-0448.

Claims Procedures

You must use and exhaust this Plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

State of Delaware as plan sponsor, has delegated final claims and appeal authority for this Plan to SilverScript. SilverScript, acting on behalf of State of Delaware, will provide the following claims and appeals review services:

- Pre-authorization review services, and
- Post-service appeals review services.

Definitions

The following terms, whether capitalized or not capitalized, are used in this booklet to describe the claims and appeals review services provided by SilverScript:

Adverse Benefit Determination – A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a plan benefit. Such denial, reduction or termination of, or failure to provide or make payment (in whole or in part) may apply to both clinical and non-clinical determinations. However, only adverse benefit determinations of a claim involving medical judgment will be eligible for external review.

Claim – A request for a plan benefit that is made in accordance with a plan's established procedures for filing benefit claims.

Claim Involving Medical Judgment – A claim for prescription drug benefits involving, but not limited to, decisions based on the plan's standards for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or involving determinations as to whether a treatment is experimental or investigational.

Prior Authorization – Approval in advance to get certain prescription drugs that may or may not be on the SilverScript formulary. Some prescription drugs are covered only if your doctor or other network provider gets "prior authorization" from SilverScript. Covered prescription drugs that need prior authorization are marked in the formulary.

SilverScript Claims and Appeals Process

Prior Authorization Review

SilverScript will implement the prescription drug cost containment programs requested by the plan sponsor by comparing member requests for certain medicines and/or other prescription benefits against pre-defined medical criteria specifically related to use of those medicines or prescription benefits before those prescriptions are filled.

If SilverScript determines that the member's request for prior authorization cannot be approved, that determination will constitute an Adverse Benefit Determination. SilverScript will send a denial letter to the member and the member's physician.

Initial Coverage Determination

A member's request for a particular drug or benefit will be reviewed and processed according to current plan rules, including that the drug or benefit is covered by the plan at the time of service.

If SilverScript determines that the member's request for a drug or benefit cannot be approved based on the terms of the Plan that determination will constitute an adverse benefit determination.

SilverScript Appeals Process

If an adverse benefit determination of the Initial Coverage Determination is rendered on the member's claim, the member may file an appeal of that determination. The appeals process has five (5) levels:

- Level 1: Redetermination by SilverScript
- Level 2: Reconsideration by an Independent Review Entity (IRE)
- Level 3: Hearing before an Administrative Law Judge (ALJ) or attorney adjudicator
- Level 4: Review by the Medicare Appeals Council (the Council)
- Level 5: Judicial review by a federal district court

Level 1 Appeal

You, your representative, your doctor, or other prescriber can request a standard or expedited redetermination of the Initial Coverage Determination. A Level 1 Appeal is handled by a SilverScript individual not involved in the Initial Coverage Determination.

A Level 1 Appeal should be filed within 60 calendar days from the date of the adverse benefit determination of the Initial Coverage Determination. The member's appeal should include the following information:

- Name of the person the appeal is being filed for
- Medicare and SilverScript Identification Number
- Date of birth
- Written statement of the issue(s) being appealed

- Drug name(s) being requested
- Written comments, documents, records or other information relating to the claim
- If you have appointed a representative, include the name of your representative and proof of representation.

The member's appeal and supporting documentation may be mailed or faxed to SilverScript at:

SilverScript Insurance Company
Prescription Drug Plans
Coverage Decisions and Appeals Department
P.O. Box 52000, MC 109
Phoenix, AZ 85072-2000

If you need help right away:
Call: 1-844-757-0448
TTY Users Call: 711
Fax: 1-855-633-7673
Hours of Operation: 24 hours a day, 7 days a week

Physicians may submit urgent appeal requests by calling the physician-only toll-free number 1-866-693-4620.

Members will receive an appeal notice with the determination of their claim. A standard appeal for a drug you have not received yet will result in a response within 7 days (or 14 days, if you are requesting repayment for a drug you have already purchased) and an expedited appeal will have a response as quickly as your health condition requires, but no later than 72 hours.

Level 2 Appeal

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

- Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:
- You **can call us at Customer Care** (phone numbers are printed on the back cover of this booklet).
- You can **get free help from** your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf**. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an

appeal.

- There may be someone who is already legally authorized to act as your representative under state law.

- If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Care (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you**. You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Level 3 Appeal

If you disagree with the determination of the IRE and the value of the drug meets a minimum dollar amount, you can request a standard or expedited reconsideration by an Administrative Law Judge (ALJ) or attorney adjudicator within 60 days from the date of the Level 2 Appeal determination notice. This gives you the opportunity to present your appeal to a new person who will independently review the facts of your appeal and listen to your testimony before making a new and impartial decision in accordance with the applicable law.

If the Level 2 Appeal issues an unfavorable determination, you may submit a written request with the information listed below. Note that if any of the described information is missing from your request for an ALJ or attorney adjudicator hearing, it can cause delays in the processing of your appeal.

- The beneficiary's name, address and Medicare health insurance claim number;
- The name and address of the appellant, when the appellant is not the beneficiary;
- The name and address of the designated representative, if any;
- The document control number assigned by the IRE, if any;
- The dates of service being appealed;
- The reasons you disagree with the IRE's reconsideration or other determination being appealed, and
- A statement of any additional evidence to be submitted and the date it will be submitted.

Send your written request for ALJ or attorney adjudicator hearing to the office specified in the Level 2 Appeal determination notice.

If you are requesting an expedited hearing, you can make an oral request. Follow the instructions in the IRE's determination notice. An expeditious decision will be decided if your doctor or other prescriber indicates, or

the ALJ or attorney adjudicator determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function.

You will be sent a Notice of Hearing with the date, time, and location of your hearing at least twenty (20) days before the hearing. Once you receive the "Notice of Hearing", fill out Response to Notice of Hearing Form (HHS-729) - PDF and return it to the ALJ or attorney adjudicator listed on the Notice of Hearing within 5 days of receiving it.

A hearing will generally be held by video-teleconference (VTC). However, an in-person hearing may be held if the ALJ or attorney adjudicator determines the circumstances of the appeal warrant an in-person hearing. Telephone hearings may also be arranged in certain circumstances for the convenience of the parties. Your hearing may take longer to schedule if the ALJ or attorney adjudicator needs to schedule a medical or non-medical expert to testify.

Members will receive a decision with the determination of their claim. A standard appeal will result in a response within 90 days and an expedited appeal will have a response as quickly as your health condition requires, but no later than 10 days. For additional information, please go to the Office of Medicare Hearings and Appeals (OMHA) website at https://www.hhs.gov/ or call (844) 419-3358.

Level 4 Appeal

If you disagree with the ALJ's or attorney adjudicator's decision, you can request a standard or expedited reconsideration by the Medicare Appeals Council (the Council) within 60 days from the date of the Level 3 Appeal decision.

If the ALJ or attorney adjudicator Level 3 Appeal issues an unfavorable determination, you may submit a written request with the information listed below.

- Beneficiary's name;
- Name of the health services provider;
- Date and type of service;
- Medicare contractor or managed care organization that issued the initial determination in your case;
- Health Insurance Claim Number (HICN);
- OMHA appeal number;
- Date of the Administrative Law Judge (ALJ) or attorney adjudicator decision or dismissal;
- An appointment of representative, such as CMS Form 1696 - PDF (PDF, 66.4 KB) (if applicable);
- Any additional evidence, clearly marked as new or duplicate; and
- Proof that you provided copies of your request to all other parties.

You may fax your request for review to (202) 565-0227 or mail your request to:

Department of Health and
Human Services Departmental
Appeals Board, MS 6127

Medicare Operations Division –
Cohen Building 330
Independence Avenue, SW,
Room G-644 Washington DC
20201

If you are requesting an expedited hearing, you can make an oral request. Follow the instructions in the ALJ's or attorney adjudicator's determination notice. An expeditious decision will be decided if your doctor or other prescriber indicates, or the ALJ or attorney adjudicator determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function.

Members will receive a decision with the determination of their claim. A standard appeal will result in a response within 90 days and an expedited appeal will have a response as quickly as your health condition requires, but no later than 10 days.

For additional information, please go to the Medicare Appeals Council (the Council) website at https://www.hhs.gov/ or call 1-800-MEDICARE.

Level 5 Appeal

If you disagree with the Council's decision, and the value of your claim meets a minimum dollar amount, you can request a judicial review by a federal district court within 60 days from the date of the Level 4 Medicare Council decision. You should contact the clerk's office of the federal district court for instructions on how to file the appeal. The court location will be on the Council's decision notice.

For more information on the appeals process:

- The State of Delaware Statewide Benefits Office website at https://dhr.delaware.gov/benefits/prescription/medicare/appeals.shtml.
- Visit https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html
- Call 1-800-MEDICARE (1-800-633-4227)
- Visit https://www.medicare.gov/forms-help-and-resources/forms/medicare-forms.html
- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling, including help with appeals. Please visit

  https://www.medicare.gov/contacts/ or call 1-800-MEDICARE for the SHIP phone number in your state.

Filing a Grievance or Complaint

If you have an issue or concern with this plan that is not a request for coverage or reimbursement for a drug, you have the right to file a complaint or grievance.

If your complaint involves the quality of care you received, you can file a grievance with SilverScript Customer Care by calling 1-844-757-0448 (TTY users only: 711) or your Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO). Visit https://www.medicare.gov/contacts/ or call 1-800-MEDICARE for the phone number of your local BFCC-QIO.

If you want to file a complaint:

- You must file your complaint within 60 days from the date of the event that led to the complaint.
- You can file your complaint and any supporting documentation with SilverScript at the following address:

  SilverScript Insurance Company
  Prescription Drug Plans
  Grievance Department
  P.O. Box 14834
  Lexington, KY 40512

  If you need help right away:
  Call: 1-844-757-0448
  TTY Users Call:
  711
  Fax: 1-724-741-4956
  Hours of Operation: 24 hours a day, 7 days a week

- You must be notified of the plan's decision generally no later than 44 days after the plan receives the complaint.
- If the complaint relates to a plans' refusal to make an expedited coverage determination or redetermination and you have not yet purchased or received the drug, the plan must notify you of its decision within 24 hours after it receives the complaint.

If the plan does not address your complaint, call 1-800-MEDICARE.

For more information on filing a complaint:

- Visit https://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals.html.
- Call your SHIP for free, personalized counseling and help filing a complaint. Call 1-800- MEDICARE or visit https://www.medicare.gov/contacts/ for the phone number of your local SHIP office.

Additional Plan Disclosures

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act ("WHCRA") of 1998, the Plan provides benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following covered health services, as you determine appropriate with your attending physician:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other covered health services provided under this Plan. Limitations on benefits are the same as for any other covered health service.

If you would like more information, please contact the Office of Pensions.

Qualified Medical Child Support Order (QMCSO)

This Plan will comply with all the terms of a qualified medical child support order (QMCSO). A QMCSO is a judgment, decree or order issued by a court or appropriate State agency that requires a child to be covered for medical benefits, and, as a result, under the Plan. Generally, a QMCSO is issued as part of a paternity, divorce or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your dependent, and the Plan will be required to pay benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedure for determining if the order is valid. Coverage under the Plan pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Pension Office.

Subrogation and Right of Reimbursement

The Plan has a right to subrogation and reimbursement as defined in your medical plan summary of benefits. Please refer to your summary of medical benefits or contact your medical plan administrator for more information.

Coordination of Benefits If You Are Covered by More Than One Medical Plan

In situations where you have other primary coverage, the Plan has a provision to ensure that payments from all of your group medical plans do not exceed the amount the Plan would pay if it were your only coverage.

The coordination of benefits rules described in your State of Delaware medical plan summary of benefits will also apply to the Plan. Please refer to that document or contact the Office of Pensions for more information on coordinating other coverage you may have.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Plan is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The State of Delaware is required to provide notice of the ways that Protected Health Information (PHI) may be used in accordance with HIPAA. A copy of the HIPAA notice of privacy practices can be obtained by contacting the Statewide Benefits Office at 1-800-489-8933 or at https://de.gov/statewidebenefits.

Circumstances That May Result in Denial, Loss, Forfeiture or Rescission of Benefit

Under certain circumstances, Plan benefits may be denied or reduced from those described in this summary of Plan benefits. Cancellation or discontinuance of coverage is permitted if it has only a prospective effect on coverage or is effective retroactively due to failure to pay required premiums or contributions.

The PDP sponsor may request to disenroll a member if his/her behavior is disruptive to the extent that his/her continued enrollment in the PDP substantially impairs the PDP sponsor's ability to arrange for or provide services to either that particular member or other members of the PDP. However, the PDP sponsor may only disenroll a member for disruptive behavior after it has met the requirements of this section and with CMS' approval. The PDP sponsor may not disenroll a member because he/she exercises the option to make treatment decisions with which the PDP sponsor disagrees. The PDP sponsor may not disenroll a member because he/she chooses not to comply with any treatment regimen developed by the PDP sponsor, or any health care professionals associated with the PDP sponsor.

Rescission of coverage is cancellation or discontinuance of coverage retroactively for reasons other than failure to pay required premiums or contributions. For example, rescission of coverage may be permitted in limited circumstances such as fraud or the intentional misrepresentation of a material fact. If coverage is subject to rescission, all affected participants must be provided with a written notice at least 30 days prior to the date of rescission.

Plan Administration

DETAILS ABOUT PLAN ADMINISTRATION	
Plan Sponsor/Plan Administrator	State of Delaware
Official Plan Name	Prescription Drug Plan Benefits for Medicare Eligible Pensioners, a component plan of the State of Delaware Health and Welfare Benefits Plan
Plan Year	January 1 – December 31
Type of Plan	Group health plan providing prescription drug benefits
Agent for Service of Legal Process	State of Delaware 841 Silver Lake Boulevard, Suite 100 Dover, Delaware 19904
Carrier/Vendor/Claims Administrator	SilverScript Insurance Company P.O. Box 30006 Pittsburgh, PA 15222-0330 1-844-757-0448 https://www.caremark.com
Plan Funding	The Plan is self-funded as part of the State of Delaware Health and Welfare Benefits Plan. Benefits from this Plan are paid from Pensioner contributions, as applicable, and from the general assets of State of Delaware, as needed. State of Delaware has contracted with third-party administrators to administer this Plan.

Plan Administrator's Discretionary Authority to Interpret the Plan

The administration of the Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretionary authority to determine all matters relating to the Plan, including eligibility, coverage and benefits.

The Plan Administrator will also have the exclusive discretionary authority to determine all matters relating to interpretation and operation of the Plan. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

The State of Delaware's Right to Amend or Terminate the Plan

It is State of Delaware's intent that the Plan will continue indefinitely. However, the State of Delaware reserves the right to amend, modify, suspend or terminate the Plan, in whole or in part. Any such action would be taken in writing and maintained with the records of the Plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and in certain circumstances, result in the reduction of or elimination of benefits or other features of the Plan to the extent permitted by law.

State of Delaware's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, HMOs, third-party administrators, etc., at any time, and the right to revise the amount of Pensioner contributions. Pensioners will be notified of any material modification to the Plan.

Limitation on Assignment

Your rights and benefits under the Plan cannot be assigned, sold or transferred to your creditors or anyone else. However, you may assign your rights to payment of benefits under the Plan to the health provider who provided the medical services or supplies.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Type of Coverage

Coverage under the plan is non-occupational. Only non-occupational accidental injuries and non-occupational illnesses are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Right of Recovery

If the amount of the payments made by SilverScript is more than it should have paid, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.