State of Delaware

Your Summary of Prescription Drug Plan Benefits for Active State Employees and Non-Medicare Eligible Pensioners

Plan Year July 1, 2021 through June 30, 2022

State of Delaware

This booklet summarizes and describes the main provisions of the prescription drug plan (Plan) made available to eligible Active State of Delaware employees and their eligible dependents and State of Delaware Non-Medicare Eligible Pensioners and their eligible dependents enrolled in the State of Delaware Group Health Insurance Plan (GHIP). The effective date of this summary is July 1, 2021.

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 CVS Caremark. If there is any difference between CVS Caremark documents and this summary, your rights will be based on the provisions of documents prepared by CVS Caremark.

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 CVS Caremark, the pharmacy benefit manager, directly at 1-833-458-0835 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 for Prescription Coverage

Active State Employees and Non-Medicare Eligible Pensioners

You are eligible to participate in the Plan if you are covered under the Highmark Delaware or an Aetna non-Medicare health plan sponsored by the State of Delaware and you meet one of the following criteria:

- You are a regular officer or employee of a State agency or school district;
- You are a non-Medicare State of Delaware Pensioner (Pensioner) receiving a State Pension;
- You are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years;
- You are regularly scheduled full-time employee of any Delaware authority or commission participating in the State's Group Health Insurance Plan (GHIP);
- You are regularly scheduled full-time employee of the Delaware Stadium Corporation, the Delaware Riverfront Corporation, or the Fort DuPont Redevelopment and Preservation Corporation;
- You are a paid employee of any volunteer fire or volunteer ambulance company participating in the GHIP;
- You are regularly scheduled full-time employee of any county, soil, and water conservation district or municipality participating in the GHIP;
- You are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/Firefighter Pension Plan with Chapter 88 of Title 11 of the Delaware Code or the county and municipal pension plan under Chapter 55A of Title 29 of the Delaware Code; or

Spouse

Your eligible spouse can also participate in the Plan if you elect medical coverage for them. An eligible spouse is one of two persons united in either:

- Marriage that is recognized by and valid under Delaware law; or
- Civil union that is recognized by and valid under Delaware law.

Information on civil union or same-gender marriage, including Frequently Asked Questions (FAQ), tax dependent status, coverage codes, health plan rates and enrollment is available at https://de.gov/statewidebenefits.

Note: The Spousal Coordination of Benefits (SCOB) Policy applies to prescription drug coverage, and is used to determine your spouse's benefit eligibility status under the GHIP. The complete SCOB Policy can be found at https://de.gov/statewidebenefits. Contact the Statewide Benefits Office at 1-800-489-8933 for more information.

Child(ren)

Your eligible child(ren) can also participate in the Plan if you elect medical coverage for them. Eligible child(ren) include:

- Your or your spouse's child(ren) who is under age 26, and either:
  - a natural born child,
  - a legally adopted child by you or your spouse, or
  - a child placed in your home for adoption.
- A child for whom health care coverage is required through a qualified medical child support order or other court or administrative order, as described in the section "Qualified Medical Child Support Order." A copy of the order must be provided to Statewide Benefits Office at 1-800-489-8933 or at benefits@delaware.gov.

Disabled Child(ren)

A dependent child(ren) age 26 or over who is disabled may be covered if:

- They were continuously covered as a dependent by a parent's health plan before reaching age 26;
- They are not married;
- They cannot support themselves because of a disability;
- Their disability happened before age 26;
- They depend on you for at least 50% of support;
- Disability is expected to last more than 12 months or results in death;
- They are not eligible for coverage under Medicare, unless federal or state law requires otherwise.

Other rules may apply in the case of divorced parents.

You must file a Request for Continuation of Coverage for Handicapped Child form with your health plan administrator. A Handicapped Child Attending Physician Statement is also required. Request the forms from the member services of your health plan administrator. You must print the form, complete it, and obtain physician's information and signature, and mail the form to the medical administrator's address that is provided on the form.

Other Child(ren)

A child who is not your or your spouse's natural born or adoptive child may be covered if the child is:

- Unmarried;
- Living with you in a regular parent-child relationship;
- Dependent on you for support and qualifies as your dependent under Internal Revenue Code Sections 105 and 152;
- Is under age 19; or
- Is a full-time student and under age 24.

For each child, you are required to show proof of dependency, such as a birth certificate, court order or federal tax return. The applicable documents must be provided to your Human Resources Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a Statement of Support form to verify you provide at least 50 percent support for the child upon enrollment and any time there are changes to the support you provide. The Statement of Support form is available at https://de.gov/statewidebenefits. Please print the form, complete it, and provide to your Human Resources Office.

You must also submit a Full-Time Student Certification form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. The Full-Time Student Certification form is available at https://de.gov/statewidebenefits. Please print the form, complete it, and provide to the Statewide Benefits Office.

Note: Your dependents (spouses and children) may not enroll in the health plan (and, therefore be covered under the Plan) unless you are also enrolled in the health plan. A dependent may also not be enrolled in more than one health option under the Plan sponsored by State of Delaware (i.e., if both parents work for a participating employer or an adult child also works for a participating employer).

Medicare Eligibility and Enrollment

You, and your spouse, are eligible to enroll in Medicare Parts A and B based on age when you turn 65 or sooner based on being disabled. In accordance with 29 Delaware Code § 5203(b) and the State of Delaware's Group Health Insurance Plan's Eligibility and Enrollment Rule 4.8.1 you and your spouse must enroll in Medicare upon eligibility. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible may result in you, as the subscriber, being held financially responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. The following information is for you and your spouse.

Medicare Part A helps cover inpatient care in hospitals and is provided at no charge to you. Medicare Part B helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care and is provided at a monthly cost to you as determined by the Social Security Administration.

If you are a benefit eligible active employee, or the spouse of a benefit eligible active employee, about three months before turning 65:

- Visit your local Social Security Administration Office and apply for Medicare Part A;
- Advise your Human Resources Office that you have applied;
- When you receive your Medicare Part A card, provide your Human Resources Office with a copy of your card.

Active employees and their spouses who are age 65 or older have a right to decide which health plan will be their primary insurer: either the employer health plan or Medicare. If you or your spouse selects Medicare as primary, the State cannot offer or subsidize a health plan to supplement Medicare's benefits. If you choose, Aetna or Highmark Delaware may remain your primary plan while you are an active employee.

About three months before retirement, you must apply for Medicare Part B. If you are a Pensioner, or the spouse of a Pensioner, about three months before turning 65:

- Visit your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B card, provide the State's Office of Pensions with a copy of your card. The Office of Pensions will enroll you in the Medicare Supplement plan, provided by the State through the Office of Pensions.

If you are a Pensioner, or the spouse of a Pensioner, and are disabled or become disabled, regardless of age:

- Visit your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B card, provide the State's Office of Pensions with a copy of your Medicare identification card. The Office of Pensions will enroll you in the Medicare Supplement plan, provided by the State through the Office of Pensions.

If you are denied enrollment in Medicare Parts A and/or B, then you are required to appeal and provide a copy of the denial and your appeal to the State's Office of Pensions. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible will result in you, as the subscriber, being held financially responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. Should Medicare deny your appeal and you provide a copy of the denial to the State's Office of Pensions, then you will continue to be covered under your non-Medicare Aetna or Highmark Delaware plan with the State's Group Health Insurance Plan.

NOTE: The classification of being “disabled” by the State of Delaware as it relates to your ability to perform your job for the State of Delaware (or another employer for a spouse) may differ from the classification of being “disabled” by the Social Security Administration, it is always your responsibility to provide the State’s Office of Pensions with your current classification by the Social Security Administration. There are special Medicare requirements regarding some health conditions, such as End Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (Lou Gehrig’s disease). Generally, you may apply to have the standard 24-month Medicare eligibility waiting period waived if you have been diagnosed with either of these conditions. Upon receiving a diagnosis of either of these conditions, whether you are an Active State of Delaware Employee or Pensioner or spouse, you should contact

Aetna’s or Highmark Delaware’s Customer Services and request information on the Medicare requirements.

Enrollment in the Plan

Enrollment Date

Your enrollment date is the later of:

- Your date of hire for Timely Enrollees (if you’re in an employee class eligible for health coverage);
- The date you move to an employee class that is eligible for health coverage (such as going from part-time to full-time employee); or,
- The date coverage begins if you’re a Special Enrollee or a Late Enrollee.

How to Enroll

You may enroll yourself and your dependents in a group health plan and the associated prescription plan when you are first eligible or at open enrollment by completing the enrollment process as designated by the Statewide Benefits Office. If you want to cover your spouse, you’ll need to complete the Spousal Coordination of Benefits Form available online at https://de.gov/statewidebenefits. Contact the Statewide Benefits Office at 1-800-489-8933 for assistance.

Coverage Levels

The coverage level you choose under your State of Delaware health plan will be the same coverage level you have under the Plan. This Plan is not a stand-alone benefit option. In other words, you may not enroll in pharmacy benefits through State of Delaware without enrolling in the underlying group health plan.

How to Decline Coverage

You may decline health and prescription drug coverage if you don’t want to enroll when you are first eligible. You will need to complete the enrollment process indicating that you are waiving coverage as designated by the Statewide Benefits Office.

Paying for Prescription Benefit Coverage

The cost of the Plan is included in the cost of the State of Delaware health plan you choose. You and the State of Delaware share in the cost of your coverage. Your portion of the cost is generally deducted from your paycheck on a before-tax basis before federal — and, in most cases, state — income taxes and FICA taxes are withheld. Expected costs and contributions are group rates — that is, they are determined by the total cost of providing coverage to all Plan participants.

When Prescription Benefit Coverage Begins

When your coverage begins is determined by:

- When you are eligible for coverage; and,
- When you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a:

- Timely Enrollee;
- Special Enrollee; or,
- Late Enrollee.

Timely Enrollees

You are a Timely Enrollee if you enroll within 30 days (30 days for newborns) of when you are first eligible to be covered.

Coverage for new employees (and their dependents) begins:

- on the date of hire; or
- on the first of the month of any month following date of hire up to the first of the month when eligible for State/Employer Share when an employee moves to a class that is eligible for health coverage.

Special Enrollees

You are a Special Enrollee if you request enrollment within the 30-day enrollment period. The enrollment period is within 30 days of:

- Losing other health coverage under certain conditions;
- Obtaining a new dependent because of marriage, civil union, birth (enrollment period is 30 days, see Changes in Enrollment / Newborns section), adoption, or placement in the home for adoption, or court ordered support.

Employees or dependents may qualify as Special Enrollees if the following requirements are met:

- Employees: if you're not already enrolled in this plan, you must:
  - be eligible to enroll in this plan; and,
  - enroll at the same time you enroll a dependent.
- Spouses and Children: you're a dependent of an employee:
  - who is already enrolled or is eligible to enroll in this plan; and,
  - who enrolls at the same time you enroll.

If you don't request enrollment within the 30-day enrollment period, you are a Late Enrollee.

Loss of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the employee or dependent) must meet all these conditions:

- You were covered under another group or individual health plan when coverage was previously offered under this plan (when first eligible or during open enrollment);
- When this plan was previously offered, you declined coverage under this plan because you had other coverage; and,
- The other coverage was either:
  - COBRA continuation coverage that is exhausted; or, other (non-COBRA) coverage that was lost because:
    - you are no longer eligible;
    - the lifetime limits under the other coverage were reached;
    - the employer stopped contributing; and, - you enrolled within 30 days of the date other coverage was lost; and
  - You can prove the loss of the other coverage by providing proof of coverage, such as a Certificate of Coverage.

New Dependents

You (employee or dependent) are a Special Enrollee if you get a new dependent because of:

- A marriage or civil union;
- Birth;
- Adoption;
- Placement of a child in the home for adoption; or,
- Court ordered support.

Coverage for Special Enrollees begins as follows if your Human Resources Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted:

- Employees: the first day of the month after the loss of coverage.
- Spouses: either the date of the marriage or civil union or the first day of the month after the marriage or civil union.
- Children: either:
  - the date of birth, adoption or placement in the home for adoption;
  - the first day of the month after you request enrollment if:
    - you lost coverage under a prior plan; or,
    - your parents got married or entered into a civil union.

Remember, if you enroll after the 30-day enrollment period, you (and your dependents) will be Late Enrollees.

Don't forget, when you get married or enter into a civil union and add your spouse, you'll also need to review the Spousal Coordination of Benefits Policy and complete the Form, available at https://de.gov/statewidebenefits and provide a copy of your Marriage/Civil Union Certificate to your Human Resources Office. The Spousal Coordination of Benefits Form must be completed online upon initial enrollment of your spouse in a State of Delaware health plan, within 30 days of your spouse losing or gaining employee coverage and every year during Annual Benefits Open Enrollment.

Late Enrollees

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at an open enrollment period. Children are Late Enrollees if enrollment was not requested within 30 days of:

- Birth (30 days);
- Adoption;
- Placement in the home for adoption; or
- Parents married or entered into a civil union.

Coverage for Late Enrollees begins the first day of the new plan year.

Making Changes during the Year

You can change your enrollment because of one of the following reasons as described below:

- Marriage or civil union
- Divorce
- Adding a newborn, adopted child, or “other” child meeting the eligibility requirements
- COBRA continuation coverage is exhausted

You must enroll yourself (and any dependents) within 30 days of the date of the event. You and your dependents will be late enrollees if you are not enrolled in the 30-day waiting period. Newborns must be enrolled within a 30-day period. Contact your Human Resources Office if you need to make a change in your enrollment during the year. If added premium is due, your payroll deductions will be adjusted accordingly.

Marriage or Civil Union

You may add your spouse when you get married or enter into a civil union. You must request enrollment within 30 days after the marriage or civil union. If added premium is due, your payroll deductions will be adjusted accordingly.

If you request enrollment within the 30-day period, your spouse will be a Special Enrollee. If you don’t request enrollment within the 30-day period, your spouse will be a Late Enrollee.

Don’t forget, when you get married or enter into a civil union and add your spouse, you’ll also need to review the Spousal Coordination of Benefits Policy and complete the Spousal Coordination of Benefits Form, available at https://de.gov/statewidebenefits, and provide a copy of your marriage or civil union certificate to your Human Resources Office. The Spousal Coordination of Benefits Form must be completed and submitted online upon initial enrollment, anytime your spouse’s enrollment or insurance status changes and each year during Open Enrollment. You may also add stepchildren you acquire when you marry or enter into a civil union. See section below describing coverage for other children.

Divorce

Former spouses are not eligible for coverage under this program. You must notify your Human Resources Office of the divorce and provide them with a copy of your divorce decree.

An enrollment form/application must be completed within 30 days of the divorce. You should state “divorce” as the reason for the change. Coverage ends on the day after the date the divorce is granted. Failure to provide notice of your divorce to your Human Resources Office will result in you being held financially responsible for the cost of the premium as well as health care and prescription services provided to your former spouse and his or her children.

Newborns

You may add your newborn child. A birth certificate or legal documentation needs to be supplied to your Human Resources Office. There is no coverage after those 30 days unless:

- You have coverage that already covers dependent children. However, you must request enrollment for the child within 30 days of the child’s birth in order for claims to process.
- You have coverage that doesn’t cover dependent children and you request enrollment for coverage that includes children. You must request enrollment for the child within 30 days of the child’s birth. If added premium is due, your payroll deductions will be adjusted accordingly.

Upon enrollment, you must provide a valid copy of the child’s birth certificate.

If you request enrollment within the 30-day period, the newborn will be a Special Enrollee. If you don’t request enrollment within the 30-day period, the child will be a Late Enrollee.

Adopted Children

You may add a child because of adoption or placement in your home for adoption. A birth certificate or legal documentation needs to be supplied to your Human Resources Office. You must request enrollment within 30 days of the date of adoption or placement in the home in order for the child to be a Special

Enrollee. If you don’t request enrollment within the 30-day period, the child will be a Late Enrollee.

Other Children

You may also cover a child who is not your or your spouse’s natural born or adoptive child if the child is:

- Unmarried; and
- Living with you in a regular parent-child relationship; and
- Dependent on you for support and qualifies as your dependent under Internal Revenue Code Sections 105 and 152; and
- Is under age 19; or
- A full-time student and under age 24.

For each child, you are required to show proof of dependency, such as a birth certificate, court order or federal tax return. The applicable documents must be provided to your Human Resources Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a Statement of Support form to verify you provide at least 50 percent support for the child upon enrollment and any time there are changes to the support you provide. The Statement of Support form is available at https://de.gov/statewidebenefits. Please print the form, complete it, and provide to your Human Resources Office.

You must also submit a Full-Time Student Certification form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. The Full-Time Student Certification form is available at https://de.gov/statewidebenefits. Please print the form, complete it, and provide to the Statewide Benefits Office.

When Continuation of Coverage Under COBRA Ends

You may have declined coverage under this plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee. When your COBRA continuation coverage is exhausted, you may request enrollment in this plan within 30 days. If you request enrollment within the 30-day period, you will be a Special Enrollee. If you don't request enrollment within the 30-day period, you will be a Late Enrollee.

HIPAA Special Enrollment Rights

Loss of Eligibility for Other Medical Coverage

If you are declining health plan enrollment, and, as a result, enrollment in this Plan, for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a health plan or switch health benefit options under the State of Delaware Group Health Insurance Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other non-COBRA coverage). However, you must request enrollment within 30 days after the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Loss of eligibility for coverage includes:

- Loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the hours of employment,
- Loss of Medicaid eligibility,
- Loss of eligibility for coverage provided through a Health Maintenance Organization (HMO) because the individual no longer resides, lives, or works in an HMO service area (regardless of whether the choice of the individual) and no other benefit package is available to the individual,
- Loss of eligibility for coverage due to the cessation of dependent status,
- Loss of coverage because an individual incurs a claim that meets or exceeds a lifetime limit on all benefits under the plan,

- A plan discontinues a benefit package option and no other option is offered,
- If the employer ceases making contributions toward the employee's or dependent's coverage, the employee or dependent will be deemed to have lost coverage and does not need to drop coverage to have special enrollment rights;
- Exhaustion of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, except that an employee/dependent losing coverage under another plan is not required to choose COBRA under that plan before using their special enrollment rights to enroll with the State; or
- Loss of individual market health insurance coverage, including coverage purchased through a Marketplace.

However, loss of eligibility for other coverage **does not include** a loss of coverage due to:

- The failure of the employee or dependent to pay premiums on a timely basis,
- Voluntary disenrollment from a plan, or
- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

Gaining a New Dependent

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in a State of Delaware health plan or switch health coverage options. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

In addition, if you are not enrolled in a State of Delaware health plan as an employee, you also must enroll in the Plan when you enroll any of these dependents. And, if your spouse is not enrolled in the health plan, you may enroll him or her in the health plan (and, therefore, in the Plan) when you enroll a child due to birth, adoption or placement for adoption.

When Coverage Begins

See the “When Prescription Drug Coverage Begins” for information on when coverage begins after loss of coverage or gaining a new dependent due to marriage, birth, adoption or placement in home for adoption.

Loss or Gain of Eligibility for a State Children's Health Insurance Program (CHIP) or Medicaid

If you (the employee) are eligible for, but not enrolled in, a State of Delaware health plan (or your dependent is eligible for, but not enrolled in, a State of Delaware health plan), you (and your dependent) may enroll in a State of Delaware health plan (and automatically receive coverage under this Plan) or switch medical benefit options, if either of the following conditions is met:

- You or your dependent is covered under CHIP or Medicaid and such coverage is terminated as a result of loss of eligibility, and you request coverage under the health plan no later than 60 days after the date of termination of such CHIP or Medicaid coverage
- You or your dependent becomes eligible for CHIP or Medicaid premium assistance subsidy with respect to coverage under a State of Delaware health plan, if you request coverage under the health plan no later than 60 days after the date you or your dependent is determined to be eligible for such premium assistance subsidy.

When Coverage Begins

If you enroll yourself, your spouse and/or your eligible dependent child(ren) in a State of Delaware health plan (and automatically receive coverage under this Plan) due to a loss or gain of eligibility for coverage event described above, see the “When Prescription Drug Coverage Begins” for information on when coverage begins. To report the qualifying event and make your enrollment changes, please contact your Human Resources Office.

Employer Children's Health Insurance Plan (CHIP) Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

When Prescription Coverage Ends

In general, coverage under this Plan will end when your State of Delaware health plan coverage ends.

Your entitlement to benefits automatically ends on the date that coverage ends. When your coverage ends, State of Delaware will still pay claims for covered prescription drugs that you received before your coverage ended. However, once your coverage ends, benefits are not provided for prescription drugs that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end if:

- Your employment with the State of Delaware ends;
- The Plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- CVS Caremark receives written notice from the State of Delaware to end your coverage;
- You become covered under another plan offered by the State of Delaware; or
- Date of your death.

Coverage for your eligible dependents will end if:

- Your coverage ends for any of the reasons listed above;
- You stop making the required contributions towards the cost of the dependent's coverage;
- CVS Caremark receives written notice from the State of Delaware to end your dependent's coverage;
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer;
- Your dependents no longer qualify as dependents under this Plan

Unless covered as a disabled child, your child's coverage ends at the end of the month in which he or she reaches:

- Age 26 if natural born or adopted child;
- Age 19 if eligible under the terms described in coverage for other children;
- Age 24 if similarly eligible and a full-time student;
- The Plan is canceled.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after your dependent reaches any limiting age.

Former spouses are not eligible for coverage. Coverage ends on the day after the divorce is granted. You must notify your Human Resources Office of the divorce and provide them a copy of the divorce decree. An enrollment form/application must be completed within 30 days of the divorce. Failure to provide notice of the divorce to your Human Resources Office will result in you being financially responsible for the cost of the premium as well as health care and prescription services provided to your former spouse and his or her children.

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: State of Delaware has the right to demand that you pay back benefits 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.

Continuation of Coverage

Coverage for a Disabled Child

If an unmarried enrolled dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as the child is fully handicapped. Your child is fully handicapped if:

- He or she is not able to earn his or her own living because of mental disability or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under the plan; and
- The child depends mainly on you for support and maintenance.

Coverage will not continue if the child has been issued an individual medical conversion policy. Coverage will cease on the first to occur:

- Cessation of the handicap.
- Failure to give proof
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

The Plan Administrator will have the right to require proof of the continuation of the handicap. Aetna or Highmark Delaware also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution, as a result from a serious illness or injury, ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student, such child's coverage under this Plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12-month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full- time student. Aetna or Highmark Delaware may require a written certification from the treating physician which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

IMPORTANT NOTE: If at the end of this 12-month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, Handicapped Dependent Children, for more information.

Continuing Coverage under COBRA

If you lose your State of Delaware health plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA). If you elect to extend your health plan coverage through COBRA, your coverage under the Plan is also extended. See the "Continuation of Coverage Rights under COBRA" section later in this summary for more information.

You also may be able to continue coverage if you are on military leave (see the "Continuation of Coverage for Employees in the Uniformed Services (USERRA) section) or if you are on an approved

Family and Medical Leave Act (FMLA) leave (see the "Continuation of Coverage While on a Family and Medical Leave" section).

As described above, you may not elect to continue prescription benefits through COBRA without choosing COBRA continuation for the underlying health plan.

Terms You Should Know

Annual out-of-pocket maximum: The most you will pay out-of-pocket for covered services, supplies and drugs each year under this Plan. The amount includes your annual deductible, your coinsurance and your copays. The annual out-of-pocket maximum does not include charges you pay for non-covered health services, any reductions in benefits you incur by not using generic and preferred drugs and any amounts that are above the reasonable and customary (R&C) charge. Once you reach the out-of-pocket maximum, the Plan pays 100% of any remaining eligible charges for that year.

Claims Administrator: 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 certain covered prescription drugs.

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

CVS Caremark Prescription Drug Benefits

When you enroll in a State of Delaware health plan, you are automatically enrolled in the Plan. You do not need to make a separate election to receive prescription benefits. You cannot elect coverage only under the Plan.

Under this Plan, your cost is lower for generic and preferred prescription drugs, which are subsidized at a higher rate. You can use one of CVS Caremark's network pharmacies nationwide to fill your prescriptions including retail CVS Caremark locations.

Under the Plan, you can obtain prescription drugs in two ways:

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

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 copay for each prescription covered under the Plan when you receive a prescription at participating retail pharmacies or through the CVS Caremark Mail Service for mail order service. You will pay your copay for each prescription until you reach the individual annual out-of-pocket maximum for the Plan. The following chart summarizes prescription drug coverage provided under the Plan**.** This chart applies to all active employees and pre-65 retirees.

How the Plan Works (for All Active Employees and Pre-65 Retirees)

The Plan applies to those enrolled in the Highmark Delaware and the Aetna non-Medicare health plans sponsored by the State of Delaware.

Three Copay/Coinsurance Levels/Tiers

The prescription drug program has three copay levels (tiers) for covered prescriptions. The amount you pay for your prescription depends on whether the drug is:

- ✓ A generic drug or a brand name drug, and
- ✓ On the CVS Caremark Formulary (a list of drugs covered under the plan).

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

- ✓ Tier one – generic drugs
- ✓ Tier two – preferred brand name drugs that are on the Formulary, and
- ✓ Tier three – non-preferred brand drugs that are not on the Formulary.

Prescription Drugs	In-Network Pharmacy	Out-of-Network Pharmacy
Up to a 30-day supply (Available at retail pharmacy or through Home Delivery)		
Tier One – Generic Drug	You pay $8 copay	Not covered
Tier Two – Preferred	You pay $28 copay	Not covered
Tier Three – Non-Preferred	You pay $50 copay	Not covered
Preventive Drugs	Certain prescription drugs classified as preventive under the Affordable Care Act are covered at 100% ($0 copay)	Not covered
Up to a 90-day supply (Available at **participating** retail pharmacies or through Home Delivery)		
Tier One – Generic Drug	You pay $16 copay	Not covered
Tier Two – Preferred	You pay $56 copay	Not covered
Tier Three – Non-Preferred	You pay $100 copay	Not covered
Maximums		
Annual Out-of-Pocket Maximum Once your out-of-pocket prescription drug expenses reach this amount, the plan will cover 100% of your eligible expenses	$2,100 per employee $4,200 per family	Not applicable
Infertility Prescription Drug Maximum	$15,000 lifetime	Not applicable

Annual Out-of-Pocket Maximum

The prescription drug copays are not applicable to the medical deductible and medical out-of- pocket maximum. The prescription drug out-of-pocket maximum is $2,100 per individual and $4,200 per family. There is no prescription drug out-of-network out-of-pocket maximum.

Once you reach your maximum out-of-pocket for your share of your covered CVS Caremark prescription drug expenses, your prescriptions will be filled at no additional charge to you for the remainder of that plan year. Both the deductible, if any, and the out-of-pocket maximum will reset every plan year.

Formulary List

The Formulary is a list that shows the generic and brand name drugs that are considered preferred drugs. The drugs on the list are preferred because of their overall ability to meet members' needs at a reasonable cost. You can reduce how much you have to pay for a prescription by using a covered generic drug (tier one) or a covered brand-name drug that appears on the Formulary (tier two – 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 (tier three – non-preferred). You can find the Formulary online at https://www.caremark.com/ or call CVS Caremark Customer Care at 1-833-458-0835. Information is also available at https://de.gov/statewidebenefits.

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 preferred brand copay of $28 for a 30-day supply; $56 for a 90-day supply.
- Certain bases, bulk compounding ingredients, compounding kits, select topical analgesics, convenience multi-product kits, hormone replacement bulk ingredients, and over the counter (OTC) products within the compound are not covered under your plan. Also, a prior authorization will be required for compounds exceeding a $300 threshold. For more information contact CVS Caremark Customer Care at 1-833-458-0835.
    - 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 a regular in-network retail pharmacy. You may want to check with your regular pharmacy before exploring other options.
    - CVS Caremark Mail Service (mail order pharmacy) does not fill prescriptions for compound medications.

If you use a non-participating compounding pharmacy, you must pay out of pocket for your prescription and submit a direct claim to CVS Caremark for partial reimbursement, based on the State of Delaware's contracted rates for the total ingredients.

Choice Program: Generic vs. Brand Medications

This program allows you to purchase a brand medication when a generic equivalent is available; however, you will pay the generic copay plus the cost difference between the generic and the brand medication. ***If there is a medical reason why you cannot take the generic equivalent***, you, your doctor or your pharmacist may initiate a ***coverage review*** to allow you to obtain the brand name drug at the non-preferred copay.

- You or the prescribing physician can send CVS Caremark a letter requesting an administrative/clinical appeal for a Benefit Copay review. A request to waive you paying the brand and generic difference.
- CVS Caremark will fax the required questionnaire to your prescribing physician to begin the appeal process.

- The appeal process could take up to 30 days before a decision is made. The urgent appeal process could take 24-72 hours to process. You or your prescriber may ask for an expedited appeal by calling CVS Caremark Customer Care at 1-833-458-0835 or by faxing your appeal to 1-866-443-1172. Urgent requests must be clearly identified as "urgent" when submitted.
- If during the appeal processing time you are out of your medication, you may obtain a short-term supply at the pharmacy but will be required pay out-of-pocket and later if the appeal is approved, you can submit a claim reimbursement request to CVS Caremark.

  **** All appeals are subject to administrative/clinical review and there is no guarantee of approval.**

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 or
- ✓ The medication is used to treat multiple conditions.

If you are taking any drugs that are subject to coverage review, CVS Caremark will need to review additional information from your doctor before a decision can be made on coverage under the prescription 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 https://de.gov/statewidebenefits for more information.

Step Therapy

Certain medications may not be covered unless you have first tried another medication or therapy. To obtain the preferred alternative medication, contact CVS Caremark Customer Care at 1-833-458-0835. If the preferred alternative medication does not show in your prescription history with CVS Caremark, 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 CVS Caremark Customer Care at 1-833-458-0835.

Preferred Specialty Management Program

Specialty medications are usually injectable medications that require special handling or safety protocols. Some specialty medications are appropriate only for limited conditions or certain patient characteristics. Preferred Specialty Management uses prior authorization and step therapy to ensure that members are taking the most clinically appropriate, cost-effective medication first.

Members may receive their first 30-day fill of a new specialty medication through an CVS Caremark participating retail pharmacy but must have subsequent refills of the same medication processed through mail order at either CVS Specialty®, an CVS Caremark specialty pharmacy, or Biotek Remedys Specialty Pharmacy. The specialty medication ***must be filled after the first fill at CVS Specialty or Biotek Remedys specialty pharmacy*** or the member will be responsible for paying the entire cost at the retail pharmacy.

Staff from CVS Specialty or Biotek Remedys will reach out to physicians and members to work together in managing the member's prescription needs. Prescriptions are delivered directly to a member's home with unique packaging as necessary, to ensure safety. CVS Specialty's dedicated customer service number is 1-800-237-2767. Biotek Remedys is located in New Castle, Delaware and their customer service number is 1-877-246-9104.

Member Cost Saving Programs

Maintenance Medication Program

Under this program, members fill 90-day prescriptions for maintenance medications for reduced copays and are charged a copay penalty if they continue to fill maintenance prescriptions every 30 days. When members receive maintenance medications every 30 days, they pay three 30-day copays in order to receive a 90-day supply of medication. Under this program, a 90-day prescription costs the same as two 30-day fills.

Maintenance Medications are those used to treat chronic conditions and long-term conditions. Examples include blood pressure medications, cholesterol-lowering medications, and asthma medications. Non-maintenance medications are those medications used to treat short-term conditions, such as bronchitis, bacterial infections, or pain following minor surgery.

A copay *penalty* will be applied beginning with the fourth 30-day fill on eligible maintenance medications that are not filled for a 90-day supply. The member must pay the 90-day copay for that medication tier as shown below.

Prescription Drugs	In-Network Pharmacy	Out-of-Network Pharmacy
Penalty: On the 4th fill of a 30-day supply of Maintenance Medication member receives a 30-day supply of medication and pays the 90-day copay		
Tier One – Generic Drug	You pay $16 copay	Not covered
Tier Two – Preferred	You pay $56 copay	Not covered
Tier Three – Non-Preferred	You pay $100 copay	Not covered

Members may continue to have their treating physician write a 30-day prescription and 90-day prescription, fill the 30-day prescription first to ensure its effectiveness; and then have the 90-day prescription filled. The penalty does not occur until a 30-day prescription is filled the fourth time.

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

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 (lancets, test strips, syringes/needles) are provided at no cost ($0 copay) when the prescription is filled at a participating retail pharmacy or the CVS Caremark Mail Service (mail order). Supplies do not need to be ordered at the same time as medications to take advantage of the $0 copay.

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 Pharmacy (mail order). For more information on the Diabetic Program, visit https://dhr.delaware.gov/benefits/prescription/diabetic.shtml.

Covered Medications

The Plan provides coverage for federal legend drugs which are drug products bearing the legend, “Caution: Federal law prohibits dispensing without a prescription.” The Plan also covers certain (medical) supplies with a prescription, emergency contraceptives and some compound medications.

For the Plan to cover a prescription, the prescribed item must meet the following requirements:

- ✓ It must be a prescription written by a licensed Prescriber (*refer to the section for “Emergency Contraception”) and not have exceeded the accepted date range of validity. Prescriptions for all drugs other than controlled substances are valid for one year from the date they were written. Controlled substance prescriptions are valid for six months from the date they are written;
- ✓ It must be approved by the Federal Food and Drug Administration (FDA);
- ✓ It must be dispensed by a pharmacy;
- ✓ It must not be listed as an exclusion under this Plan.

Prescription drugs covered by the Plan are classified as either generic or brand-name drugs. Brand-name drugs are then considered either preferred brand-name or non-preferred brand-name.

Preventive Drugs Covered at 100%

In accordance with the Patient Protection and Affordable Care Act (ACA), members enrolled in Highmark Delaware or Aetna non-Medicare Health Plan may receive coverage through the CVS Caremark pharmacy benefit for the following preventive medications. **Please note:** Most medications are covered at $0 copay, while others may require a copay under the prescription drug or health plan. Age limit restrictions apply to certain medications for children, adolescents and adults.

To obtain these preventive medications, the member must present a doctor’s prescription for the medication to a participating CVS Caremark pharmacy, even if the medication is available over-the-counter (OTC).

- Aspirin – Generic Agents
- Oral Fluoride
- Folic acid – Generic Agents
- Statins – Generic Agents
- Immunizations / Vaccines
- Smoking Cessation

- Bowel Prep Agents
- Breast Cancer Prevention – Generic Agents
- HIV PrEP – Generic Agents

For an updated list of preventive medications covered in full under ACA, please visit https://de.gov/statewidebenefits. The limitations and restrictions that apply to these medications are shown on the website.

In accordance with the Affordable Care Act (ACA), the plan covers generic and certain brand-name contraceptives at 100% with no member cost sharing or copayment. Other brand-name contraceptives are covered by the plan and subject to a copayment. Please reference the **Preventive Medications & Services covered by the plan document** available online at https://de.gov/statewidebenefits. Under Benefits Administered by Statewide Benefits, select the CVS Caremark Prescription Plan icon. The CVS Caremark – Wellness, Preventive Care and Condition Care Coordination section is where you will find this document.

Emergency Contraceptives

Emergency contraceptives are available over-the-counter and can be dispensed with or without a prescription at a CVS Caremark participating retail pharmacy. You may submit a paper claim form along with original receipts directly to CVS Caremark for reimbursement of the covered expenses. **Claims must be filed within 90 days of the prescription fill date**.

To obtain a claim form, call CVS Caremark Customer Care at 1-833-458-0835 or visit www.caremark.com to access and print claim forms. You should submit your claim form to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

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 CVS Caremark's network. To find out if your pharmacy is affiliated with CVS Caremark, for instructions on filing claims, for refills and for status of an order call CVS Caremark Customer Care at 1-833-458-0835.

Women's 12-Month Contraceptives:

The State of Delaware allows a prescription for contraceptives to be filled at the pharmacy for a full 12-month period which may be dispensed all at once or over the course of the 12-month period.

- If a member wants a 12-month supply; the prescription needs to be written for a quantity of 12 months.
- If the prescription is written for 3 months with refills, the pharmacy will not be able to dispense the entire 12 months all at once. A new prescription must be presented to the pharmacy for the remainder of the 12-month period. For example, if you are 3 months into your 12 month (3 refills) annual prescription and you want to obtain the remaining 9 months at your next fill, you can. However, the prescriber will need to write a new prescription for a supply of 9 months.

Please note: The plan covers generic and certain brand-name contraceptives at 100% with no member cost sharing or copayment. Other brand-name contraceptives are covered by the plan and subject to a copayment.

Clinical Trials

Prescription drug coverage may also be available in connection with your participation in certain approved clinical trials with respect to the treatment of cancer or another life-threatening disease or condition. If you are eligible to participate in such an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either (1) the referring health care professional is a participating provider and has concluded that your participation in such trial would be appropriate; or (2) you provide medical and scientific information establishing that your participation in such trial would be appropriate, then the plan will not deny, limit, impose additional conditions on, or discriminate against you in connection with your participation in such an approved clinical trial.

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
- Blood Glucose Monitors not issued by Livongo®
- Mifeprex
- Cosmetic and hypopigmentation drugs
- Anti-Obesity Preparations, Weight Loss Medications
- Dental fluoride products except where mandated by ACA
- Allergy Sera and 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

Standard Control Formulary drug exclusions (varies by year). For a list of the most recent formulary exclusions, visit https://de.gov/statewidebenefits. Select your group, then select the CVS Caremark Prescription Plan icon for Formulary information. Note that the Plan Administrator may make changes to this list of exclusions at any time. If you are uncertain whether the drug that your physician has prescribed is covered by the Plan and CVS Caremark, please call CVS Caremark at 1-833-458-0835 to confirm or visit the website at www.caremark.com.

Other Plan Program Information

All Infertility Services

Members receiving any infertility service, including but not limited to in-vitro fertilization (IVF) and artificial insemination, are required to pay a 25% coinsurance for prescriptions associated with all infertility services. There is a $15,000 lifetime maximum for all prescriptions for infertility under the State of Delaware prescription plan.

CVS Caremark will track medications to determine when the lifetime maximum of $15,000 has been reached. Members are responsible for paying 25% coinsurance for all prescriptions at the time of pick up or mail order.

If you are charged incorrectly or have additional questions, please contact the Statewide Benefits Office at 1-800-489-8933.

Prescription Drug Coverage Provided by your State of Delaware Health 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 your State of Delaware health plan. You must follow normal medical claim procedures for reimbursement for these drugs.

Your ID Card

When you first enroll in your State of Delaware health plan, you will receive an identification card from CVS Caremark. If you need additional cards (for instance, if your child is attending college out of town), you can request them by calling CVS Caremark Customer Care at 1-833-458-0835. You are also able to print a temporary identification card from CVS Caremark's website, www.caremark.com or download the CVS Caremark mobile app for free to your mobile device and register your account. It is important to remember to use your Plan ID card at the pharmacy rather than your health plan's insurance card.

When You Need to Fill a Prescription

When you need to fill a prescription, you can choose to go to a participating retail pharmacy or, for mail order, use the CVS Caremark Mail Service. If your prescription is for a 30-day supply of a medication or less, one of the retail options is best.

Regardless of whether you choose a participating pharmacy or the CVS Caremark Mail Service, 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 CVS Caremark formulary list. Your doctor decides 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

CVS Caremark has contracted with retail pharmacies, including most major drug stores and local pharmacy locations. These retail pharmacies in the CVS Caremark 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 CVS Caremark network.

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 CVS Caremark network) while you are traveling 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 CVS Caremark for reimbursement of the covered expenses. **Claims must be filed within 90 days of the prescription fill date**.

To obtain a claim form, call CVS Caremark Customer Care at 1-833-458-0835 or visit www.caremark.com to access and print claim forms. You should submit your claim form to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

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 CVS Caremark’s network. To find out if your pharmacy is affiliated with CVS Caremark, for instructions on filing claims, for refills and for status of an order call CVS Caremark Customer Care at 1-833-458-0835.

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 CVS Caremark. CVS Caremark, acting on behalf of the 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 CVS Caremark:

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.

Final Internal Adverse Benefit Determination – An adverse benefit determination that has been upheld by the plan at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the "deemed exhaustion" rules of the ACA.

Independent Review Organization (IRO) – An entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations pursuant to the requirements of the ACA.

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.

Medically Necessary (Medical Necessity) – Medications, health care services or products are considered medically necessary if:

- Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated
- Use of the medication, service, or product is based on recognized standards for the health care specialty involved

- Use of the medication, service, or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed, and
- Use of the medication, service or product is not solely for the convenience of the member, member's family, or provider.

Post-Service Claim – A claim for a plan benefit that is not a pre-authorization claim.

Pre-authorization – CVS Caremark's pre-authorization review of a member's initial request for a particular medication. CVS Caremark will apply a set of pre-defined medical criteria (determined by the State of Delaware) to determine whether there is need for the requested medication.

Pre-Authorization Claim – A claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-authorization claims include member requests for pre-authorization.

Urgent Care Claim – A claim for a medication, service, or product where a delay in processing the claim: (i) could seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, or (ii) in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the requested medication, service, or product. CVS Caremark will defer to the member's attending health care provider as to whether or not the member's claim constitutes an urgent care claim.

CVS Caremark Claims and Appeals Process

Initial Review

Pre-authorization Review

CVS Caremark will implement the prescription drug cost containment programs requested by the Plan Administrator 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 CVS Caremark determines that the member's request for pre-authorization cannot be approved, that determination will constitute an Adverse Benefit Determination. CVS Caremark will send a denial letter to the member and the member's physician.

Review against the Plan's Terms

A member's request for a particular drug or benefit will be compared against the preferred drug lists or formularies selected by the State of Delaware before the member's prescription is filled.

If CVS Caremark determines that the member's request for a drug or benefit cannot be approved based on the terms of the Plan, including the preferred drug lists or formularies selected by the State of Delaware, that determination will constitute an adverse benefit determination.

Notice of Adverse Benefit Determination

Following the review of a member's claim, CVS Caremark will notify the member of any adverse benefit determination in writing. (Decisions on urgent care claims will be also be communicated by telephone or fax.) This notice will include:

- The specific reason or reasons for the adverse benefit determination
- Reference to pertinent plan provision on which the adverse benefit determination was based
- A statement that the member is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either a copy of the specific rule, guideline, protocol or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request, and

Authority as Claims Fiduciary

CVS Caremark shall serve as the claims fiduciary with respect to preauthorization review of prescription drug benefit claims arising under the Plan, first-level review of appeals of pre-authorization clinical claims and review of post-service claims and administrative denials. CVS Caremark shall have, on behalf of the Plan, sole and complete discretionary authority to determine these claims conclusively for all parties.

Level I Appeal – Administered by CVS Caremark

If an adverse benefit determination is rendered on the member's claim, the member may file a Level I appeal of that determination. The member's appeal of the adverse benefit determination must be made in writing and submitted to CVS Caremark within 180 days after the member receives notice of the adverse benefit determination.

If the adverse benefit determination is rendered with respect to an urgent care claim, the member and/or the member's attending physician may submit an appeal by calling CVS Caremark.

The member's appeal should include the following information:

- Name of the person the appeal is being filed for
- CVS Caremark 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.

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

Non-Specialty Appeals:

Prescription Claim Appeals MC 109
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072

Fax: 1-866-443-1172

Specialty Appeals:

CVS Caremark
Specialty Appeals Department
800 Biermann Court
Mount Prospect, IL 60056

Fax: 1-855-230-5548

Physicians may submit urgent appeal requests by calling Customer Care at 1-833-458-0835 or by faxing the appeal to the applicable fax number specified above. Urgent requests must be clearly identified as "urgent" when submitted.

CVS Caremark's Review

Review of adverse benefit determinations of pre-authorization clinical claims: CVS Caremark will provide the Level I review of appeals of pre-authorization clinical claims. Such claims will be reviewed against pre-determined medical criteria relevant to the drug or benefit being requested.

Timing of Review

Pre-Authorization Review — CVS Caremark will make a decision on a pre-authorization request for a plan benefit within 15 days after it receives the request. If the request relates to an urgent care claim, CVS Caremark will make a decision on the Claim within 72 hours.

Pre-Authorization Clinical Claim Appeal — CVS Caremark will make a decision on a Level I appeal of an adverse benefit determination rendered on a pre-service clinical claim within 15 days after it receives the member's appeal. If CVS Caremark renders an adverse benefit determination on the Level I appeal of the pre-service claim, the member may appeal that decision by providing the information described above. If the member is appealing an adverse benefit determination of an urgent care claim, a decision on such appeal will be made not more than 72 hours after the request for appeal(s) is received (for both the Level I and Level II appeals, combined).

Administrative Denial or Post-Service Claim Appeal — CVS Caremark will make a decision on an appeal of an adverse benefit determination rendered on a post-service claim or on an administrative denial within 30 days after it receives such appeal.

Scope of Review

During its pre-authorization review, Level I review of the appeal of a pre-service clinical claim or review of a post-service claim or administrative denial, CVS Caremark shall:

- Take into account all comments, documents, records and other information submitted by the member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination on the claim,
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable plan documents,
- Follow reasonable procedures to ensure that the applicable plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly-situated members,
- Provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual), and
- Have an Appeals Analyst review appeals relating to non-clinical benefits (e.g., eligibility determinations, copay issues, explicit exclusions under the benefit plan). An Appeals Pharmacist will review appeals relating to clinical knowledge (e.g., prior authorization denials).

Level II Appeal – Administered by CVS Caremark

If the member's Level I appeal is denied, the member may file a Level II appeal of that determination. The member must file a Level II appeal within 180 days from receipt of the Level I appeal decision. The process for filing a Level II appeal is the same as described above for a Level I Appeal.

If the member is appealing an adverse benefit determination of an urgent care claim, the member would skip the Level II appeal and move directly to a Level III appeal.

CVS Caremark approves or denies the Level II appeal with written notice to the member:

- Within 15 days for Pre-Service requests,
- Within 30 days for Post-Service requests, or
- Within 72 hours for expedited appeals under certain conditions.

Level III Appeal Options:

Members may submit a Level III appeal to either or both the State of Delaware Statewide Benefits Office (SBO) or an external review to CVS Caremark.

Level III Appeal – Administered by the Statewide Benefits Office

The member may file an appeal of the denial in writing to the Statewide Benefits Office within 20 days of the postmark date of the notice of denial of the Level II appeal (or an urgent level appeal) and/or notice of the denial of the Level III external review appeal.

Please submit Level III appeals to the Statewide Benefits Office at this address:

Appeals Administrator
RE: APPEAL
Statewide Benefits Office
Enterprise Business Park
97 Commerce Way, Suite 201
Dover, DE 19904

Appeal must contain the member's contact information (mailing address, email address, telephone number, etc.) a written summary of events, applicable Explanation of Benefits (EOBs), and any additional documentation the member desires to provide to support his/her position. Additionally, the member must sign and submit with appeal the State of Delaware's Authorization for Release of Protected Health Information form to provide authorization to the Statewide Benefits Office to obtain applicable information from CVS Caremark.

This form is available at: https://de.gov/statewidebenefits (Select your group, then select the CVS Caremark Prescription Plan tile, under "I WANT TO…" select "Appeal a Denied Claim"). Members submitting an appeal without the signed form will be requested, in writing, to submit the form.

The Statewide Benefits Office will not begin to review the appeal until the State of Delaware's Authorization for Release of Protected Health Information form is received.

The Appeals Administrator from the Statewide Benefits Office (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the member and CVS Caremark within 30 days of receiving the appeal.

Level III Appeal – Administered by CVS Caremark

Federal External Review Process (Non-Expedited)

If the member's Level II appeal is denied, the member may request, in writing, an additional Level III medical necessity review, an external review of such claim. This request must be made within four (4) months after receiving the notice of the final internal adverse benefit determination. The member's request should include the member's name, contact information including mailing address and daytime phone number, member ID number and a copy of the coverage denial. The member's request for external review and supporting documentation may be mailed or faxed to CVS Caremark at:

Prescription Claim Appeals MC 109
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

The review of whether the requested drug or benefit is medically necessary will be conducted by an Independent Review Organization (IRO). Within five days of receiving a plan member's request for external review CVS Caremark will conduct a "preliminary review" to ensure that the request qualifies for external review. In this preliminary review, CVS Caremark will determine whether:

- ✓ The member is or was covered under the plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, was covered at the time the prescription drug benefit was provided
- ✓ The adverse benefit determination or final internal adverse benefit determination does not relate to the member's failure to meet the plan's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for federal external review
- ✓ The member has exhausted the plan's internal appeals process (unless the member's claim is "deemed exhausted" under the ACA), and
- ✓ The member has provided all the information and forms necessary to process the external review.

In addition, CVS Caremark will review the member's request for external review to determine whether it involves a claim involving medical judgment. If CVS Caremark determines that the request does not involve a claim involving medical judgment, it will forward the member's request for external review to an Independent Review Organization (IRO) for further review. The IRO will determine whether the member's request for external review involves a claim involving medical judgment as soon as possible.

Within one day after completing its preliminary review, CVS Caremark will notify the member, in writing, that: (i) the member's request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

Referral to an Independent Review Organization (IRO)

If the member's request for external review is complete and the member's claim is eligible for external review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify the member of its acceptance of the assignment. The member will then have 10 days to provide the IRO with any additional information the member wants the IRO to consider.

CVS Caremark will also forward or cause to have forwarded to the IRO applicable medical records, documentation, plan language and specific criteria.

CVS Caremark is not responsible for the conduct of any second-level medical necessity review performed by an IRO.

The IRO will select an independent specialist to conduct its external review without giving any consideration to any earlier determinations made on behalf of the plan. The IRO may consider information beyond the records for the member's denied claim, such as:

- ✓ The member's medical records
- ✓ The attending health care professional's recommendations

- ✓ Reports from appropriate health care professionals and other documents submitted by the plan, the member, or the member's treating physician
- ✓ The terms of the plan to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law)
- ✓ Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national, or professional medicine societies, boards, and associations
- ✓ Any applicable clinical review criteria developed and used on behalf of the plan (unless the criteria are inconsistent with the terms of the plan or applicable law)
- ✓ The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the member's request for external review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate, and
- ✓ Information from the plan member's or beneficiary's provider as requested by the IRO if the IRO considers additional information necessary or potentially useful in the review.

Timing of IRO's Determination

Written notice of its final external review decision will be provided to CVS Caremark for communication to the member within 45 days after the IRO receives the request for external review.

The IRO's written notice will contain:

- ✓ A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount if available, and the reasons for the previous denials)
- ✓ The date the IRO received the external review assignment from CVS Caremark, and the date of the IRO's decision
- ✓ References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination
- ✓ A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision
- ✓ A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the plan or to the member
- ✓ A statement that the member may still be eligible to seek judicial review of any adverse external review determination, and
- ✓ Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman available to assist the member.

If an adverse benefit determination is based on a medical necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Plan to the member's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

Reversal of the Plan's Prior Decision

If CVS Caremark receives notice from the IRO that it has reversed the prior adverse determination of the member's claim, CVS Caremark will immediately provide coverage or payment for the claim.

If a member appeals CVS Caremark's denial of a pre-authorization clinical claim, and requests an additional second-level medical necessity review by an IRO, the IRO shall:

- ✓ Consult with an appropriate health care professional who was not consulted in connection with the initial adverse benefit determination (nor a subordinate of such individual)
- ✓ Identify the health care professional, if any, whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, and
- ✓ Provide for an expedited review process for urgent care claims.

Federal External Review Process (Expedited)

A member may request an expedited external review:

- ✓ If the member receives an adverse benefit determination related to a claim involving medical judgment that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, and the member has filed a request for an expedited internal appeal, or
- ✓ If the member receives a final internal adverse benefit determination related to a claim involving medical judgment that involves; (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the member, and/or could result in the member's failure to regain maximum function, or (ii) an admission, availability of care, continued stay, or a prescription drug benefit for which the member has received emergency services, but has not been discharged from a facility.

Request for Review

If the member's situation meets the definition of urgent under the law, the external review of the claim will be conducted as expeditiously as possible. In that case, the member or the member's physician may request an expedited external review by calling the number on the member's benefit ID card or contacting the benefits office. The request should include the member's name, contact information including mailing address and daytime phone number, member ID number, and a description of the coverage denial.

Alternatively, a request for expedited external review may be faxed; member contact information and coverage denial description and supporting documentation may be faxed to the attention of CVS Caremark Prescription Claims Appeals at 1-866-443-1172. All requests for expedited review must be clearly identified as "urgent" at submission.

Preliminary Review

Immediately on receipt of a member's request for expedited external review, CVS Caremark will determine whether the request meets the reviewability requirements described above for standard external review. Immediately upon completing this review, CVS Caremark will notify the member that: (i) the member's request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

Referral to IRO

Upon determining that a member's request is eligible for expedited external review, CVS Caremark will assign an IRO to review the member's claim. CVS Caremark will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review the member's claim de novo and will not be bound by the decisions or conclusions reached on behalf of the plan during the internal claims and appeals process.

Timing of the IRO's Determination

The IRO must provide the member and CVS Caremark, on behalf of the Plan, with notice of its determination as expeditiously as the member's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the member's request for external review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide the member and CVS Caremark, on behalf of the plan, with written confirmation of its decision.

Authority for Review

CVS Caremark will be responsible for conducting the preliminary review of a member's request for external review, ensuring that the member is timely notified of the decision as to eligibility for external review, and for assigning the request for external review to an IRO. The actual external review of a member's appeal will be conducted by the assigned IRO.

Level IV Appeal – Administered by the State of Delaware – State Employee Benefits Committee (SEBC)

The member may file a written appeal to the State Employee Benefits Committee (SEBC) within 20 days of the postmark date of the notice of denial for the Level III appeal from the Statewide Benefits Office.

Please submit Level IV appeals to the SEBC at this address:

Co-Chair, State Employee Benefits Committee (SEBC)
RE: APPEAL
Department of Human Resources
Haslet Armory, Second Floor,
122 Martin Luther King Boulevard South
Dover, DE 19901

The SEBC receives the appeal and:

a) Identifies a Hearing Officer (Division Director, Statewide Benefits Office). The Hearing Officer conducts a hearing and submits a report to the SEBC within 60 days of the date of the hearing. The SEBC accepts or modifies the report, and notice of the decision is postmarked to the member within 60 days; or

b) Hears the appeal and notice of the decision is postmarked to the member within 60 days of the hearing.

Additional Plan Disclosures

Women's Health and Cancer Rights Act 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 Statewide Benefits Office at 1-800-489- 8933 or at https://de.gov/statewidebenefits.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

This Plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., the physician, nurse, midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, the Plan will not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hours (or 96 hours) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan will not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify your medical administrator. For information on notification or prior authorization, contact the Statewide Benefits Office at 1-800-489-8933 or at https://de.gov/statewidebenefits.

Qualified Medical Child Support Order (QMCSO)

The 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 Statewide Benefits Office at 1-800-489-8933.

Subrogation and Right of Reimbursement

The Plan has a right to subrogation and reimbursement as defined in your health plan summary. Please refer to that summary or contact your health Plan Administrator for more information.

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

In situations where you have other primary coverage, the Plan has a provision to ensure that payments from all of your group health 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 health plan summary will also apply to the Plan. Please refer to that document or contact the Statewide Benefits Office for more information on coordinating other coverage you may have.

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. 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.

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.

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. Health plan coverage may be continued under certain circumstances under the Federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

Continuing Coverage through COBRA

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 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.

COBRA Qualifying Events

If you are an **employee**, you will become a qualified beneficiary if you lose coverage under the Plan because either of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the **spouse of an employee**, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- Entitlement to Medicare benefits, or
- You become divorced or legally separated from your spouse.

Your **dependent children** will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than his or her gross misconduct,
- Entitlement to Medicare benefits,
- The parents become divorced or legally separated, or
- The child stops being eligible for coverage under the Plan as a "dependent child."

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. For example, any increase in the premium or contribution that must be paid by you (or your covered spouse or dependent children) for coverage under the Plan that results from the occurrence of a qualifying event is a loss of coverage.

Notification a COBRA Qualifying Event Has Occurred

A group health plan must offer COBRA continuation coverage only to qualified beneficiaries and only after a qualifying event has occurred. The employer, employee or beneficiary must notify the group health plan of the qualifying event, and the plan is not required to act until it receives an appropriate notice.

The employer must notify the COBRA Administrator **within 30 days** if the COBRA Qualifying Event is:

- Termination or reduction in hours of employment of the covered employee,
- Death of the covered employee,
- Covered employee becoming entitled to Medicare, or
- Employer bankruptcy.

The covered employee or former eligible dependent must notify the plan **within 60 days** if the qualifying event is:

- Divorce/Legal separation, or
- A child's loss of dependent status under the plan.

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will end when the first of the following occurs:

- The COBRA continuation coverage period ends
- Required premium is not paid on time

- Become covered (as an employee or otherwise) under another group health plan (not offered by State of Delaware)
- Become entitled to (that is, enrolled in) Medicare benefits. This does not apply to other qualified beneficiaries who are not entitled to Medicare
- State of Delaware ceases to provide any group health plan for its employees and retirees

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

If You Have Questions

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.

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.

Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). If you elect to continue your State of Delaware health plan coverage, your Plan coverage will also continue.

The terms "Uniformed Services" or "Military Service" mean the Armed Forces (that is Army, Navy, Air Force, Marine Corps, Coast Guard) the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus any additional seniority, rights and benefits that you would have attained if employment had not been interrupted.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the plan administrator in advance and providing payment of any required contribution for the health coverage. This may include the amount the plan administrator normally pays on an employee's behalf. If an employee's military service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An employee may continue Plan coverage under USERRA for up to the lesser of:

- The 24-month period beginning on the date of the employee's absence from work or
- The period running from the day the leave begins through the day the leave ends.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Regardless of whether an employee continues health coverage, if the employee returns to a position of employment, the employee's health coverage and that of the employee's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Generally, total leave, when added to any prior periods of military leave from the State of Delaware, cannot exceed five years.

Employees who do not return to work at the end of military leave may be entitled to purchase COBRA continuation coverage. Any COBRA continuation period for which the employee is eligible will run concurrently with any USERRA continuation period for which the employee is eligible. Employees who do not return to work at the end of military leave may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which employees and/or their dependents may be eligible.

You should call the plan administrator if you have questions about your rights to continue health coverage under USERRA, or would like to receive a copy of the Plan’s USERRA Policy and Procedure free of charge.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), if you meet eligible service requirements, you are entitled to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time. The State of Delaware is required to maintain group health plan coverage for an employee on FMLA leave: a) if the employee had such coverage before taking the leave, and b) on the same terms as if the employee had continued to work. If applicable, employees may need to make arrangements will need to pay their share of group health plan contributions while on leave. In some instances, the State of Delaware may recover contributions it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child or parent who has a serious health condition
- For your own serious health condition
- For “any qualifying exigency” (a qualifying urgent situation or pressing need) arising out of the fact that the spouse, son, daughter or parent of the employee is on active duty or called to active duty status as a member of the regular Armed Forces, the National Guard or Reserves in support of a contingency operation. For all qualifying exigency leave, the military member must be deployed to a foreign country
- For any qualifying exigency for parental care leave to provide care necessitated by the covered active duty of the military member for the military member’s parent who is incapable of self-care.

In addition, an eligible employee who is the spouse, son, daughter, parent or next of kin (that is, nearest blood relative) of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. An eligible employee can also take leave to care for certain veterans with a serious injury or illness incurred or aggravated in the line of duty while on active duty and that manifested before or after the veteran left active duty. Military caregiver leave is also allowed for an eligible employee to care for current service members with serious injuries or illnesses that existed prior to service and that were aggravated by service in the line of duty on active duty.

This military caregiver leave is available during “a single 12-month period” during which an eligible employee is entitled to a combined total of 26 weeks for all types of FMLA leave. See

U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, for Fact Sheets #28 and #28A, which provide further details on FMLA (http://www.dol.gov/compliance/laws/comp-fmla.htm).

Depending on the state where you live, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements. You may also be eligible for paid leave related to qualifying family and medical reasons under state or jurisdictional law.

Plan Administration

DETAILS ABOUT PLAN ADMINISTRATION	
Plan Sponsor/ Plan Administrator	State of Delaware
Official Plan Name	State of Delaware Prescription Drug Plan, a component plan of the State of Delaware Group Health Insurance Plan
Plan Year	July 1 – June 30
Type of Plan	Group health plan providing prescription drug benefits
Agent for Service of Legal Process	State of Delaware 97 Commerce Way, Suite 201 Dover, DE 19904
Carrier/Vendor/Claims Administrator	CVS Caremark Customer Care Correspondence PO Box 6590 Lee's Summit, MO 64064-6590 1-833-458-0835 www.caremark.com
Plan Funding	The Plan is self-funded as part of the State of Delaware Group Health Insurance Plan. Benefits from this Plan are paid from employee contributions, as applicable, and from the general assets of the State of Delaware, as needed. State of Delaware has contracted with CVS Caremark, a third-party administrator, 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 may, 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 employee contributions. Employees 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.

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 CVS Caremark 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.

Your Employment

This summary provides detailed information about the Plan and how it works. This summary does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the Plan should not be interpreted as an implied or express contract or guarantee of employment. The State of Delaware's employment decisions are made without regard to benefits to which you are entitled upon.

The Plan's benefits are administered by State of Delaware, the Plan Administrator. CVS Caremark is the pharmacy benefit manager responsible for processing claims for the Plan and providing appeal services; however, CVS Caremark and the State of Delaware are not responsible for any decision you or your dependents make to receive treatment, services or supplies. CVS Caremark and the State of Delaware are neither liable nor responsible for the treatment, services or supplies provided by participating or non-participating providers.

Updated for July 2021